County of Los Angeles

2006-2007 Civil Grand Jury

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George Buckley
Nola Burnett
Stuart L. Chason
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Final Report

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INTRODUCTION

LOS ANGELES COUNTY CIVIL GRAND JURY

The 2006-2007 Los Angeles Civil Grand Jury served from July 1, 2006 to June 30, 2007. The following provides a broad overview of the Civil Grand Jury, its history, what it is and how it functions.

HISTORY

The grand jury system has its historical roots in the old English grand jury system, the purpose of which was to protect citizens from the arbitrary power of the Crown. The American system continues to retain the goal of protecting residents from abuse by local government.

DEFINITIONS

Section 888 of the California Penal Code provides that a civil grand jury be comprised of the required number of citizens charged and sworn to investigate into county matters of civil concern. Based upon its population, the required number of Civil Grand Jurors for Los Angeles County is 23.

FUNCTIONS

The Civil Grand Jury functions as one independent body. All matters discussed are kept private and confidential. It is the responsibility of the Grand Jury to examine all aspects of county and local government to ensure they are being operated honestly and efficiently.

The Civil Grand Jury is mandated by law to respond to letters of complaint by citizens and to inquire into the conditions of public detention facilities.

REQUIREMENTS TO BECOME A GRAND JUROR

In order to be selected as a grand juror, an individual:

- Must be a citizen of the United States, 18 years of age or older and a resident of the State of California and Los Angeles County for at least one year immediately prior to selection
- Must not be serving as a trial juror in any California court
- Cannot have been discharged as a Grand Juror in any California court within one year of the beginning date of service
- Cannot have been convicted of malfeasance in office or any felony or other high crime.
- Must possess sufficient knowledge of the English language.

- Must be in possession of his or her natural faculties, be of ordinary intelligence, sound judgment and good character.

TERM OF SERVICE

Each July 23 citizens of Los Angeles County are sworn as Civil Grand Jurors to serve for a period of twelve months. Civil Grand Jury duty is a full time job, with each Jury establishing its own work schedule. Everyone who is nominated to serve must be fully cognizant of the time involved. Each prospective nominee should thoughtfully weigh any and all personal and business obligations before accepting the nomination.

The Superior Court Judges nominate persons representing the cultural, ethnic and diverse life experience of residents of Los Angeles County so that the Civil Grand Jury may reflect the many interests and concerns of the citizens. Following the nominations, the selection process for grand jurors involves a random choice of prospective jurors and alternates.

COMPENSATION

A Grand Juror receives $60 for each day's attendance, plus mileage at the current available rate and free parking. If a Grand Juror chooses to use public transportation to sessions of the Grand Jury, he or she will be reimbursed for the cost of that transportation.

FOR MORE INFORMATION OR AN APPLICATION, PLEASE WRITE OR CALL:

Los Angeles Superior Court
Civil Grand Jury Coordinator
210 West Temple Street
Eleventh Floor – Room 11-506
Los Angeles, CA 90012
Telephone (213) 893-1047
FAX (213) 229-2595
http: //grandjury.co.la.ca.us

County of Los Angeles
Civil Grand Jury

Clara Shortridge Foltz Criminal Justice Center
210 West Temple Street · 11th Floor, Room 11-506 · Los Angeles CA 90012
Telephone (213) 893-1047 · FAX (213) 229-2595
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FOREPERSON'S LETTER

It has been an honor and privilege to be selected by the Judges' Grand Jury Committee to serve as the foreperson of the 2006-2007 Los Angeles Civil Grand Jury. We are twenty-three randomly selected citizens of the County of Los Angeles acting on behalf of all the citizens to investigate the functioning of all aspects of county government. We are mandated by law to inquire into the conditions and management of public jails. In addition, we select specific topics to investigate based on current issues or previous Grand Jury reports. Simply stated, we function as the "watchdog" for the citizens of the county. Those investigative topics require a majority vote of 14 members. Our tenure is from July 1, 2006 to June 30, 2007, and at the end of the year our final report becomes public.

The members of this year's Civil Grand Jury have been professional, dedicated, and committed to this enormous and important responsibility placed upon them. I am honored to have been a part of their efforts and accomplishments. Our public report will leave a legacy of which we all can be proud, and serve as a professional standard for future Grand Jury Committees. The selection of topics for investigation, by majority vote, from a diverse membership requires respect, tolerance, and participation of all members.

The standing Committee Chairpersons have achieved standards and goals which far exceeded my expectations. It is due to them and their committee members' active participation and dedication that we have accomplished so much in what seems to be a very brief period of time. The Transitional manuals are a new administrative addition to our efforts this year and will assist the 2007-2008 Civil Grand Jury as they learn about their responsibilities and duties.

We have searched for the root cause of each problem or status concern investigated and constructed an objective unbiased investigation to arrive at conclusions and recommendations. I hope our unique perspective provides information which will enable the County to improve the functions and services provided to its citizens.

As the foreperson of this year's Grand Jury, I would like to reflect on the Health and Social Services, which account for 1/3 of the county's responsibility and expenses and much of the county's 90,000 employee efforts. As we all know, the County of Los Angeles is the largest county in the nation. Inmates with psychiatric needs constitute a major proportion of those incarcerated within Twin Towers and the Sheriff's Department, and their Medical Services

Bureau, work in conjunction with the Department of Mental Health to provide appropriate healthcare. There is an urgent need to better utilize information technology to help coordinate and share medical, social, legal, and education information between all Departments as it relates to each citizen within the County. The inefficiency that now exists leads to delay, duplication, and inappropriate care all of which are time-consuming, labor intensive, and costly.

There is a need to have someone with governance to oversee the implementation of electronic records, protocol sharing, information sharing, and data analysis in and between Departments. The official creation of a Chief Executive Officer (CEO) as of July 1, 20067, should expedite the coordination and implementation of this countywide effort. The recently signed Memorandum of Understanding (MOU) of May 9, 2007, involved DHHS, DMH, DCFS, and Probation regarding disclosures of health and mental health information. These departments all have custody of minors, and this MOU may be the catalyst for removing barriers to sharing information pertinent to the care of the dependents and wards of the County.

There are over 100,000 dependent children and adolescents within the Department of Children and Family Services or are clients of the Juvenile Court. Many are in Home and Residential Based Facilities 24 hours a day, 7 days a week. Each Civil Grand Jury should voluntarily or by change in the statute include inspection of these facilities as part of the Civil Grand Jury's responsibility. There is a need to assist in the oversight of care and protection of vulnerable and at-risk children. One of our committees included visits to a selected sample of congregate care facilities as part of their investigation.

I would like to thank the Judges of the Superior Court who are associated with the Civil Grand Jury for their guidance. A special thank you goes to the Grand Jury staff for their support and encouragement. We miss the accomplishments, leadership, and camaraderie of Robert George. His sudden, heart-wrenching illness required him to withdraw from the Civil Grand Jury on November 28, 2006. I would like to conclude with a final thanks to the families of the 2006-2007 Civil Grand Jury who have allowed us the time to complete the task.

Robert Sax
Foreperson

2007 - 2008 Civil Grand Jury

Back Row
Otha Scott, Sandra Lee Mohr, Nola Burnett, Stuart L. Chason, Charles Repp, Jr., George Buckley, Lewis Hastings, John Visser, James Tasker, John Hackney, Carole Greene

Front Row
Ung Yol Yu, Bill Wagner, Emilie Anselmo, Marlene Markheim, Hannah Margolis, Robert E. Sax, Linda Winfield, Joe Contreras, Connie Leyba, Richard Lorne Davis, Walter Lappo

Absent
Lloyd Thornhill

CIVIL GRAND JURY ROSTER
County of Los Angeles

2006-2007 Civil Grand Jury Roster

Robert E. Sax, Foreperson	San Marino
John Hackney, Foreperson pro tem	Glendora
Linda F. Winfield, Secretary	Los Angeles
Walter Lappo, Treasurer	Burbank
George Buckley, Sergeant at Arms	Hermosa Beach
Emilie Anselmo	Altadena
Nola Burnett	Inglewood
Stuart L. Chason	Santa Monica
Joe Contreras	Arcadia
Richard Lorne Davis	Glendale
Robert George	Valley Village
Carole Greene	Los Angeles
Lewis Hastings	Los Angeles
Connie Leyba	South Pasadena
Hannah Margolis	Beverly Hills
Marlene Markheim	Encino
Sandra Lee Mohr	Northridge
Charles Repp Jr.	Marina Del Ray
Otha Scott	Compton
James Tasker	Los Angeles
Lloyd Thornhill	San Dimas
John Visser	Encino
Bill Wagner	Sherman Oaks
Linda F, Winfield	Los Angeles

INVESTIGATIONS

Avoiding Code Blue

Safeguard for Patient Medications

Avoiding CodeBlue Committee

George Buckley, Chair
Linda F. Winfield, Chair

Nola Burnett
Suart L. Chason
Joe Contreras
Walter Lappo
Otha Scott

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

AVOIDING CODE BLUE

LOS ANGELES CIVIL GRAND JURY 2006-2007

The County of Los Angeles Department of Health Services is responsible for providing health care for all the citizens of the county regardless of their ability to pay. They work in conjunction with other County departments to provide health and social services to those that require assistance. The 2006-2007 Los Angeles County Civil Grand Jury approved an investigation into the safeguards against medication errors in place for the inpatient (receiving care in a hospital) and out patient (receiving care without being hospitalized) pharmacy services.

PART A Safeguards of outpatient medication

PART B Safeguards for inpatient medication

AVOIDING CODE BLUE
SAFEGUARDS FOR OUTPATIENT MEDICATION

EXECUTIVE SUMMARY

The responsibility of providing pharmaceutical services in a County of 10,000,000 residents is a formidable challenge. The 2006-2007 Civil Grand Jury chose to investigate the County's efforts to provide safe and cost effective medication.

The investigation was based on a 2007 study and report of medical errors by the Institute of Medicine that cited details of medication errors that resulted in huge costs and patient illnesses and deaths.

The objectives of this investigation were to document procedures for identifying preventable errors and examine the use of information technology in Los Angeles county facilities. The investigation was divided into two sections to evaluate services to outpatients inpatients (*those who are not hospitalized)* and to inpatients (*those hospitalized*). Outpatients are served by both free standing outpatient clinics and outpatient departments of hospitals.

The Department of Health Services (DHS) has implemented a comprehensive system to prevent medication errors. The system is used for outpatient care by the outpatient departments of hospitals and the outpatient clinics. The Jury's recommendation is for DHS to continue and further expedite the implementation and installation of the Pharmacy 2000 system throughout the network of County hospitals and clinics.

HISTORY

The Institute of Medicine's (IOM) 1999 report, *To Err is Human*[1], on the extent of medical errors in U. S. hospitals caused commotion among the public and health care professionals. More individuals die because of medical errors each year than in the workplace, accidents, motor vehicles, breast cancer and AIDS[2]. Both consumers and physicians rated medical errors as a low priority on a list of health care issues; however 42% of the public and 35% of physicians surveyed indicated they had experienced a medical error in their own care or that of a family member[3].

---

[1] Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, (Eds.) To Err is human: Building a safer health system. Institute of Medicine, Washington, D.C. Institute of Medicine, National Academy Press, (1999).
[2] Terrence Kinniger & Lee Reeder (2003). "The business case for medication safety," Healthcare Financial Management. Westchester, February, Vol. 57, 32, 46.

[3] Blendon, R. J., DesRoches C.M., Brodie M., Benson J. M., Rosen A.B., Schneider E., Altman D.E., Zapert K., Hermann M. J., Steffenson A. E., "Patient safety: Views of practicing physicians and the public on medical errors," New England Journal Medicine, 347, 1993-1940, (2002).

Although the understanding of the costs of medication errors is incomplete, a conservative estimate of extra costs of inpatient care based on 400,000 preventable adverse drug events (an injury due to medication) was an annual cost of $2.3 billion in 1993 dollars or $3.5 billion in 2006 dollars[4]. Another study found that 530,000 preventable adverse drug events occur among outpatient Medicare patients resulting in an annual cost of $887 million[5] .

Since the time of the IOM Report, progress has been made due to more regulation, improved information technology, and workforce organization and training. For example, the Food & Drug Administration (FDA) has a new regulation requiring bar codes on prescription drugs to help prevent medication errors[6]. Bar codes will catch the error at the point of administration as well as errors in the process before they reach the patient. However, there are still many opportunities for improvement in error reporting systems, information technology and accountability necessary to improve patient safety[7].

A recent study found that there are still huge gaps in the knowledge base with respect to medication errors. Current methods for communicating information about medication were found to be inadequate and contribute to the incidence of errors. Moreover, the incidence rates and costs of medication errors in many care settings, and the effectiveness of prevention strategies are still not well understood[8].

This issue was of such importance that the state of Indiana implemented a medical error reporting system for all medical facilities to obtain data that could be used: 1) towards reducing the frequency of medical errors, 2) revealing the causes of medical errors, and 3) empowering health care professionals to design methods to prevent errors before patients are harmed. For 2006, there were a total of 287 facilities which reported seventy-seven (77) events. Seventy-two (72) occurred at hospitals while five (5) events occurred at ambulatory surgery centers[9].

In the hospital, there are **more than twenty steps** involved from the doctor's prescription to administration to a patient. Estimates of the range and types of medication errors indicate that 39-49% occur when physicians are ordering medication, 26-36% occur at the time a nurse administers medication, 11-12% are transcription errors, and 11-14% occur at the time a pharmacist dispenses the medication. These estimates are illustrated in Exhibit 1.

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[4] Phillip Aspden, Julie Wolcott, J. Lyle Bootman, Linda R. Cronenwett, (Ed.) Preventing Medication Errors: Quality Chasm Series. Institute of Medicine, 2007, http://www.nap.edu/catalog/11623.html.

[5] Institute of Medicine, Report Brief: Preventing Medication Errors, July 2006, http://www.nap.edu/

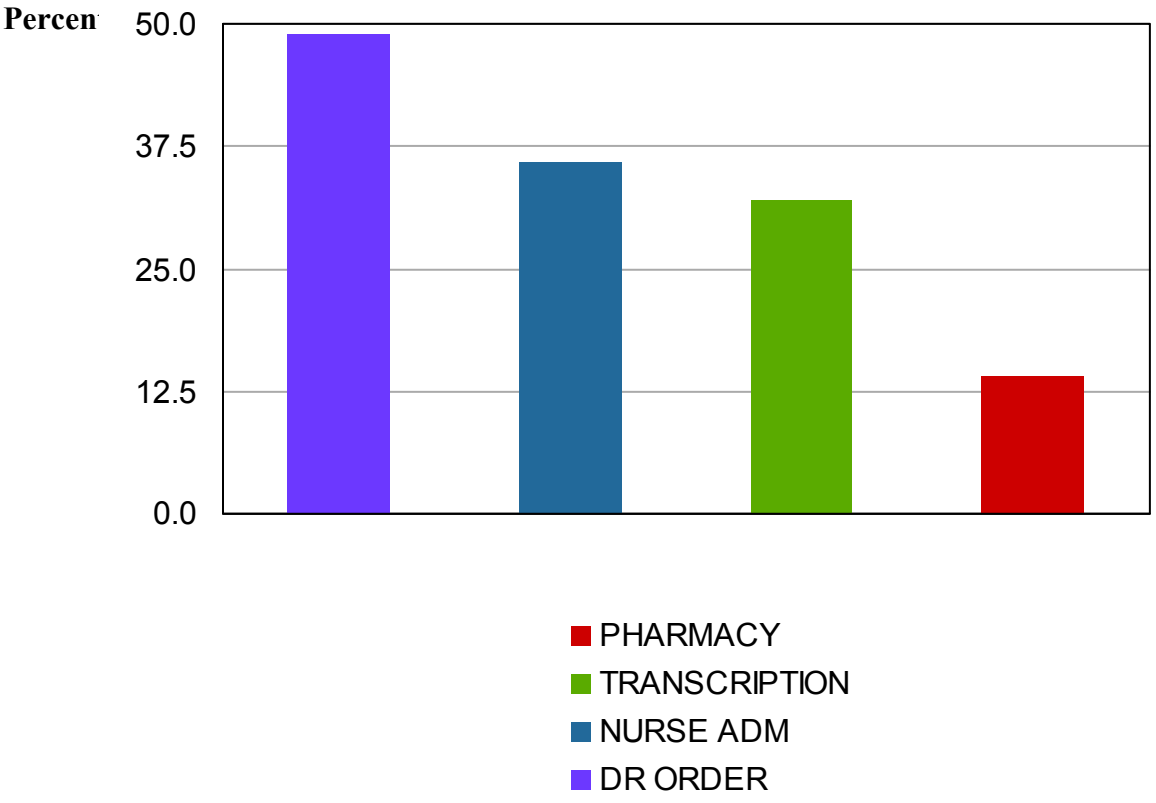
[6] Markian Hawryluk. "FDA targets medication errors by requiring bar codes on drugs". American Medical News, Chicago, March 15, Vol. 47 # 11, 1, (2004).

[7] Robert M. Wachter, "The End of the Beginning: Patient Safety Five Years After 'To Err is Human'", Health Affairs, Web Exclusives A Supplement to Health Affairs, Volume 23, Supplement 2, July-December, 534-435 (2004).

[8] Aspden et al., 2007., 2.

[9] Judith A. Monroe and Mary Hill, Indiana Medical Error Reporting System. Preliminary Report for 2006. Indianapolis, Indiana, Indiana State Department of Health, (2006). http://www.in.gov/isdh.

Exhibit 1



OUTPATIENT PHARMACY

There are relatively few reports in the literature about medication errors in outpatient pharmacies. Most studies were conducted by pharmacists and focused primarily on admission medication orders compared with previous outpatient medication. One study found that the admission medication discrepancy ranged from 11- 46%[11]. The Joint Commission on

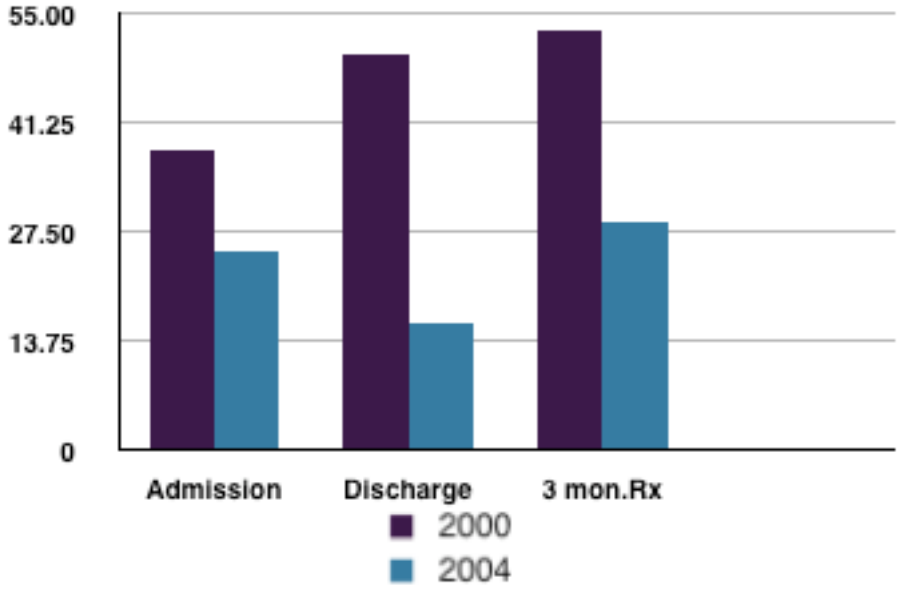
[10] American Board of Quality Assurance and Utilization Review Physicians (2004).
[11] Charles S. Salemi and Norvella Singleton, "Decreasing medication discrepancies between outpatient and inpatient care with computerized pharmacy data". Permanente Journal, Spring, Vol. 11, No, .2, 1-6, (2007). <http://wwwxnet.kporg/permanentejournal/spring07/decreasing.html>

Accreditation of Healthcare Organizations (JCAHO) instituted a new regulation in 2006 to improve patient safety by decreasing medication errors. This requires a process for obtaining and documenting a complete list of each patient's current medications at hospital admission and communicating this list to the next clinician[12] ("Medication Reconciliation").

One study found that medication discrepancies between outpatient and inpatient care could be decreased with computerized pharmacy data, the KP Patient Data System (KPDS). The researchers used outpatient medication prescriptions in 2000 and 2004 using computer generated data for patients admitted from an Emergency Department to a medical ward. The hospital records and pharmacy data were reviewed to determine which ambulatory medications were ordered at admission, continued as an outpatient, and refilled three months after discharge. In 2004 additional data from KPDS, the *Care Management System* (CMS) were provided to attending physicians. The results indicated that there was improvement in all three categories after providing (CMS) data: 1) admission orders, 2) discharge summaries, and 3) three month prescription refills. The largest medication discrepancy noted was an omission of the patient's previous ambulatory medication. These results are shown in Exhibit 2.

Exhibit 2

[13]



Another study indicated that in a setting where there is a high-volume of prescriptions being filled, an automated prescription refill program resulted in time and cost savings. This system

[12] Joint Commission on Accreditation of Healthcare Organizations, (2005) National Patient Safety Goals, Oakbrook Terrace (IL): Joint Commission on Accreditation of Healthcare Organizations, http://www.jointcommission.org/GeneralPublic/NPSG/o6_gp_npsg.htm.

[13] Salemi and Singleton, 2007.

linked patient phone requests for refills with its central pharmacy computer to automate processing of requests and filling prescriptions[14].

Los Angeles County

The Department of Health Services (DHS) provides medical care, which includes pharmaceutical services, to the citizens of Los Angeles County through a network of hospitals and medical clinics. The clinics provide outpatient services and prescriptions.
DHS is charged with providing health care services to over 10 million citizens of Los Angeles County.

PURPOSE

Because of the increased public awareness of medical errors and a general concern for the well being of the citizens of Los Angeles County, the Los Angeles Civil Grand Jury decided to investigate the use of technology in the healthcare system for the administration and delivery of pharmaceuticals in the Los Angeles County Hospitals and Clinics. It is our responsibility to ensure that the County provides the highest level of patient safety in connection with an efficient and cost effective system.

INVESTIGATION

Methodology

The methodology for the investigation consisted of site visits to a selected sample of Los Angeles County Hospitals and outpatient clinics, interviews with key personnel in DHS, hospital CEO, pharmacy administrators, pharmacists and technicians at each site. The literature on medication errors and documents obtained from DHS were reviewed. A list of the site visits and presentations are listed below:

Twin Towers Medical Services Division Automated Pharmacy
Interview and meeting with Director of Pharmacy Affairs

Harbor UCLA Hospital, inpatient and outpatient pharmacy
Meeting with CEO, Director, Pharmacy Services, and other key personnel

Hubert H. Humphrey (HHH) Comprehensive Care Center
Orientation by Director and key staff
Demonstration of Pharmacy 2000 system

[14] Algis Rudinskas, "Automated prescription refills retain customers and revenues". Santa Clara Valley Medical Center implements IVR (interactive voice response) for processing prescriptions. Health Management Technology Online, (1999). 1, http://www.healthmgttech.com.

LAC/USC inpatient pharmacy
Meeting with CEO, COO, Director, Pharmacy Services

Presentation to the Civil Grand Jury by Director of Pharmacy Services
Presentation to Civil Grand Jury by Director, DHS and Chief Medical Officer, and key staff

Presentation to the Civil Grand Jury regarding Health Care Plan by CEO (COPE) dealing with health solutions in County

Meeting with Senior Medical Director, Chief Nursing Officer, and Chief Information Officer

FINDINGS

Automated pharmacies are being installed in DHS outpatient clinics.

Hubert H. Humphrey Comprehensive Health Center has installed an automated pharmacy that will serve as a model for other outpatient clinics. The Pharmacy 2000 system by McKesson features bar coded orders for easy tracking and includes additional safety checks for high alert medication. Other completed installations include Martin Luther King-Harbor Hospital's outpatient pharmacy, LAC-USC outpatient pharmacy, and Roybal Comprehensive Health Clinic.

A schedule of completed and scheduled installations completed was obtained from the Department of Health Services, Pharmacy Affairs. This information is listed in Exhibit 3.

Exhibit 3

DHS Outpatient Pharmacy Automation Installation Plan: Expected Order of Installation Status, May 2007

Installation Date	Facility	Status of System Installation	Structural Remodel Required
1996	Martin L. King-Harbor	Completed and operational since 1996	Yes-completed
Jan-06	Humphrey CHC	Installed 1/17/06	Yes-completed
Jul-06	LAC+USC OPD	Installed July 2006	Yes-completed
Aug-06	Roybal CHC	Installed August 2006	Yes-completed
Estimated February 2008	Long Beach CHC	Remodel scheduled to be completed by December 2007. with installation by February 2008	Remodel of outpatient pharmacy area scheduled for May-Nov. 2007
Estimated April 2008	Rancho Los Amigos	Architectural review of facility floor plans in progress	Facility completed a remodel in 2006
Estimated July 2008	El Monte CHC	Architectural plans in place. Awaiting completion of remodeling	Entire outpatient pharmacy remodel scheduled for the next 12 months. Board letter requesting funding approval sent in May 2007
Estimated August 2008	Harbor UCLA sites (3)	Remodeling in place for required Senate Bill 1953 earthquake retrofit. Installation must be conducted after structural modifications are in place.	Outpatient Pharmacy SB 1953 remodeling estimated to take place by July 2008, allowing for P2000 installation.
Estimated October 2008	Hudson CHC	Pending remodel of outpatient pharmacy	Entire outpatient pharmacy remodel scheduled for the next 12 months
Estimated October 2008	Valley Care sites (3)	Pending SB1953 remodeling, which is required by State law, SB 1953 remodeling will incorporate P2000 automation installation.	Outpatient Pharmacy SB 1953 remodeling estimated to take place by September 2008, allowing for P2000 installation.
Unknown at this time pending mail order pilot	High Desert MACC	Installation is currently in the decision making process. As DHS is considering a mail order pilot for this location, there may not be the prescription volume to automate, particularly if most prescription refills are processed via mail order. To be assessed after determination of success of mail order pilot.	

Knowledge sharing and standards development have been implemented to reduce pharmaceutical errors.

The DHS Core Pharmacy & Therapeutics (P&T) Committee was formed to develop and maintain a uniform drug formulary for all DHS patient care sites. The objective of the committee was to create the formulary based upon the optimization of drug effectiveness, safety, evidence based reports and cost effectiveness. In addition, at each individual hospital facility, a local (P&T) committee meets on a regular basis to review and evaluate issues related to the effectiveness of pharmaceutical delivery and administration.

LAC/USC has taken a leadership role in patient safety, which includes pharmaceutical processes.

USC/LAC is the largest teaching hospital in the country with 7500 employees, 800 residents, and over 1 million outpatient visits per year. A patient safety office has been implemented which includes pharmacy. A medication safety committee reviews all processes, protocols and procedures related to medication safety, reviews trends, reviews "high alert" medications as part of a regulatory requirement. LAC/USC has filled 2.4 million prescriptions per year for outpatients without error. The Comprehensive Health Clinics include three satellite sites which each serve 100,000 patients per year.

The Hubert H. Humphrey Comprehensive Clinic has the capacity to fill a large number of prescriptions in a timely and cost efficient manner.

The Hubert H. Humphrey Clinic, one of the LAC/USC satellites fills 33,000 prescriptions a year, and averages 1,346 prescriptions each day.
See Exhibit 4.

Exhibit 4

Hubert H. Humphrey Comprehensive Clinic Department of Pharmacy
Outpatient Pharmacy Report January 2007

Total Number of Prescriptions	**33,497**
Average number of prescriptions per day	
Monday-Friday	1,346
Weekends and Holidays	525
Average Rx processing time	47 minutes
8:30 am – 11 am	15 min – 1 hr
11:00 am – 2 pm	45 min – 1 ½ hr
2 pm – 12 pm	15 min – 1 ¼ hr
Average staffing per day	
Monday-Friday (pharmacist/tech/typist-window-stock)	8/10/4.5
Weekends and Holidays (pharmacist/tech/typist-window-stock)	3/3/2
Clinical interventions per month	21
Patient counseling by pharmacists per month	278

HHH Clinic has implemented specific policies (effective 3/6/06) to require verification of the patient's identity before providing services.

At least two patient identifiers will be used when administering medication or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatment or procedure[15]. The staff is required to verify patient's identity by requiring two accepted forms of identification.

There is a low level of health literacy among the outpatients being served by the County, particularly as it relates to medication use.

From our interviews and meetings, one of the issues raised was that individuals coming for care often do not bring a list of their medications or know the dosage. This lack of information may result in unsafe care or may present a risk for adverse drug interaction.

The process of automation includes several safety features to avoid medical errors, save time and costs and better tracking.

When a patient has visited the clinic and has a prescription from a clinic physician, the prescription is input into the system by a pharmacy technician.

- The software evaluates the prescription for adverse drug interactions and other discrepancies based on patients' allergies, weight, height and dosage. Specific "high alert" medications are flagged and require additional verification. If no discrepancies are found, the prescription is transmitted to another technician in a different location in the pharmacy.

- This technician has several sets of prescriptions assigned, and they are prioritized using color codes. The technician reviews the prescriptions in the set, and each is assigned a cabinet. AccuMed automatically dispenses medications such as pills or capsules. This cabinet has medications in bulk and dispenses the required amount when activated. A light goes on where the dispensed medications are located.

- The technician applies a computer printed label to the proper sized container and releases the dispensed medication into the container. The label provides instructions as well as name of drug, strength, dosage, form of administration, manufacturer's name, date, and lot number, and an illustration of the actual pill for visual verification. The automated dispensing system reduces human errors, such as misreading bulk medication labels. The automation also saves time since the technician does not have to count the medications. Non pill form medications (e.g., inhaler liquids, etc. are labeled with the computer generated labels.

[15] Hubert H. Humphrey Comprehensive Community Health Center Policy and Procedure, Division: Medical Administration, Number 1031, Patient Identification, effective 3/6/06.

- When the set of prescriptions is completed, a light is lit on the pharmacist's side of the cabinet. When the pharmacist is ready, he or she opens the cabinet and checks the medications against the original orders as well as for other errors. If the medications are correct, he or she approves them, puts them in plastic bags and hangs them with bags for other patients filed by the last two numbers of their medical record and by their name.

- The checking of the finished products by the pharmacist is conducted by using the last two numbers of the patient's medical record as well as the patient's name, which reduces the chance of providing the medication to the wrong patient. The identity of the technician and pharmacist is bar coded in the system to allow for a review of the process. The pharmacist provides the patient with the medication.

Future improvements of pharmacy service include the filling of reorders at a remote site.

Patients, especially those requiring long term medication may call a number in advance of running out of the prescription. The system will be automated so that the patient can input information on the keypad of his or her telephone. The process is flexible for the patient as the medication could be sent to the patient's home, the clinic, or a local pharmacy.

LAC/USC, in cooperation with public/private partnership with the County has a pilot program to provide a system of high quality care in local outpatient clinics for the uninsured.

Indirectly related to pharmaceutical issues, COPE Health solutions provide preventive health care in conjunction with the county and community clinics. The *Camino de Salud* program provides services to those requiring management of chronic disease and offer education on preventive health care. They also arrange coordinated specialty care to meet the demands. This program assures coordination of care, and has incorporated a unique identification (ID) number on clients served to coordinate medical information. Two thousand five hundred (2,500) patients used this service from 5/1/06 to 1/31/07. This pilot program increases health care access and quality at a reduced cost[16].

[16] Allen Miller and Nicole Ramos, Camino de Salud Network Data Report, January, LAC/USC Healthcare Network, Cope Health Solution, (2007), http://www.copehealtsolution.org.

CONCLUSION

The 2006 -2007 Civil Grand Jury believes that the Pharmacy 2000 system, that was evaluated and approved for installation throughout the County's medical clinics, is an effective system that meets or exceeds the objectives of meeting patient safety, efficiency and cost effectiveness. However, future plans should include studies of medication reconciliation in Los Angeles county hospitals and outpatient pharmacies.

In summary, in the investigation of medication errors in Los Angeles County, the improvement in outpatient safety stems from a committed cadre of highly professional individuals who understand both the technical and human processes involved in outpatient pharmacy. However, the collection of accurate and useful data is required for continuous improvement. This would include not only information concerning medical errors, but also timely, action-oriented information and data needed to recognize and understand problems, prioritize solutions, and assess the impact of change when implementing new technology.

RECOMMENDATIONS

1. The Jury recommends that DHS continue and expedite the installation and implementation of the Pharmacy 2000 system.

2. The Jury recommends that DHS implement the Structured Physician Order Form, to include the block lettering utilized at Harbor UCLA, in all County healthcare facilities to improve legibility and accuracy in orders.

3. The Jury recommends that DHS implement a health literacy and drug safety program to educate the patients served about the medications used, when coming to a clinic or hospital.

4. The Jury recommends that DHS implement the automated refill by phone prescription service as soon as possible.

5. The Jury recommends that DHS have a system of tracking and interface between hospitals and outpatient clinics to maintain a continuity of care. Information technology should be used to facilitate this process. A similar tracking and interaction should be established between all County departments providing health and social services for the citizens of Los Angeles County, including the Jails.

APPENDIX A - ACRONYMS

ABQUARP	American Board of Quality Assurance & Utilization Review Physicians
IOM	Institute of Medicine
FDA	Food and Drug Administration
JCAHO	Joint Commission on Accreditation of Health Care Organizations
CMS	Care Management System
DHS	Department of Health Services
HHH	Hubert H. Humphrey Comprehensive Clinic
CEO	Chief Executive Officer
CIO	Chief Information Officer
COO	Chief Operating Officer
KPDS	Kaiser Permanente Data System
ID	Identification
IVR	Interactive voice response
OPD	Outpatient-Department

APPENDIX B - Bibliography

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AVOIDING CODE BLUE:

SAFEGUARDS FOR INPATIENT MEDICATION

I – EXECUTIVE SUMMARY

The County of Los Angeles Department of Health Services (DHS) manages four Hospitals with more than 1,500 beds. Rancho Los Amigos specializes in rehabilitative care, while the rest of the Hospitals provide comprehensive services, including emergency departments. DHS also is responsible for Martin Luther King-Harbor, a 25-bed facility that was not included in this evaluation because it is in transition from independence to management by Harbor.

DHS has implemented programs to reduce medication errors at the facilities that have improved outcomes in all categories of error. Under the leadership of the Director, Pharmacy Services, DHS has instituted a system-wide formulary, optimizing the number and range of medications. DHS has introduced new medication order processing and dispensing technology. The Department has also adopted several best practice processes to reduce medication error risk. Among these initiatives are:

Multiple reviews during the ordering, dispensing, and administering stages of medication provision
Clinical Resource Management (CRM) Pathways
Medication Order Scanning System
Pharmacy Information System
Automated Dispensing Cabinets (ADCs)
IV Smart Pumps
On-line drug information in Patient Care units
Clinical Pharmacists
Physician Order Forms for Admissions and Transfers

In addition, DHS is developing plans to implement medication and bedside bar-coding by working with it suppliers to develop a standardized bar coding system.

Much has been accomplished, but more should be done to reduce risk of medication error. Specifically, the 2006-2007Civil Grand Jury (CGJ) recommends:

Table 1: Findings and Recommendations

#	Finding	Recommendation
1.	DHS central staff Directors have established spheres of influence when working with the Hospitals, but they lack formal authority relationships and audit functions.	The Director, Pharmacy Services, should be entrusted with the authority to carry out medication error risk, performance audits and business process reviews.

#	Finding	Recommendation
2.	Investments in technology can result in significant reductions in medication error risks.	DHS should invest in medication management technology improvements, using life cycle costing that accounts for acquisition, installation, and maintenance of equipment. Funding for these investments should be drawn in part from medication cost savings such as those attributable to improved acquisition management.
3.	Olive View Medical Center processes appear to be incompatible with the realization of ADC benefits.	As part of the implementation of ADCs at Olive View, DHS should review the complete medication order, delivery, and administration process to ensure that both the baseline process and the plan to strengthen it with ADC technology are sound.
4.	Electronic Health Records and Computerized Physician Order Entry, when properly implemented, are best practices to reduce medication error.	DHS should begin now to plan for the implementation of Computerized Physician Order Entry and Electronic Health Records.
5.	Clinical Pharmacists are effective in reducing medication error risks.	DHS should expand the number of Clinical Pharmacists, institute a Clinical Coordinator position at each Hospital, and use Tech-Check-Tech processes to free Pharmacists to perform other pharmaceutical duties
6.	24-hour Pharmacist coverage is important to Patient Safety.	DHS should immediately establish a 24-hour Pharmacy at Olive View Medical Center, and monitor Rancho Los Amigos Rehabilitation Center off-hours demands for medication.
7.	It is a common practice to conduct pre-employment drug testing among staff involved in the health care professions. DHS does not do this.	The County should implement pre-employment drug screening and should develop a targeted program to provide for early identification and treatment of substance abuse among staff with access to controlled medications.
8.	A "Safe and Just" culture is essential to accurate self-reporting of errors – including medication errors – as well as to the rapid and effective response to error trends.	DHS should strengthen its "Safe and Just" culture.
9.	There is insufficient consistent, Department-wide medication error trend analysis.	DHS should analyze medication error trends, share aggregated information with Departmental and Facility leadership, and allow central review of medication error reports.

#	Finding	Recommendation
10.	The number of minor errors causing no patient harm (Category A - C in University HealthSystem Consortium – the Patient Safety Net) is less than expected, and raises the possibility that they are not fully self-reported.	DHS should consider establishing Nurse "Naïve Observation" auditing to reduce dependency on self-reporting for medication errors.
11.	DHS does not have a regular practice of replicating the best practices implemented from one facility to another.	DHS should recognize best practices implemented at one facility, and replicate them system-wide.

II – HISTORY AND BACKGROUND

HOSPITALS' BACKGROUND

The Los Angeles County Department of Health Services (DHS) operates four major hospitals, Harbor-UCLA Medical Center (Harbor-UCLA), Los Angeles County+USC Medical Center (LAC+USC), Rancho Los Amigos Rehabilitation Center (RLA), and Olive View Medical Center (Olive View). Together, they provide more than 300,000 patient days of care annually.

Table 2: Size of Hospitals

Hospital	# of Beds		Average Daily Census
	Licensed	Budgeted	
Los Angeles County+USC Medical Center	1022	685	628
Harbor–UCLA Medical Center	570	332	355
Rancho Los Amigos Rehabilitation Center	395	147	140
Olive View Medical Center	377	195	196

The Centers provide a wide variety of services:

LAC+USC is the largest single provider of health care in Los Angeles County, providing a full spectrum of emergency, inpatient and outpatient services. LAC+USC provides the community with more than 28% of its trauma care. It operates one of three burn centers in the County and one of the few Level III Neonatal Intensive Care Units in Southern California. It provides care for one-half of both AIDS patients and sickle cell anemia patients in Southern California.

RLA is one of the largest comprehensive rehabilitation centers in the United States.

Harbor-UCLA is a Level 1 Trauma Center with an NIH-funded General Clinical Research Center. The 72-acre facility is composed of the 8-story Hospital, and a 52,000 square foot Primary Care and Diagnostic Center.

Olive View is an acute care Hospital. Table 3 includes the list of services provided at each Center.

Table 3: Specialty Services Provided

Hospital	ER	OR	Oncology	ICU	Neo-Natal
Los Angeles County+USC Medical Center	X	X	X	X	X
Harbor – UCLA Medical Center	X	X	X	X	X
Rancho Los Amigos Rehabilitation Center		X		X	
Olive View Medical Center	X	X	X	X	X

MEDICATION ERRORS

Medication errors are classified according to severity by the standards established by the University HealthSystem Consortium – the Patient Safety Net (UHC PSN). They include:

No patient harm categories:

Category A – Unsafe conditions
Category B1 – No harm, near miss because of chance alone
Category B2 – No harm, near miss because of active recovery
Category C – No harm, and does not require increased patient monitoring

More serious but no permanent harm to patient categories:

Category D – Required increased monitoring to ensure no harm to patient
Category E – Temporary harm to patient, which does not require treatment or intervention
Category F – Temporary harm to patient which requires intervention

Most severe categories:

Category G – Permanent patient harm
Category H – Intervention required to sustain life
Category I – Patient death

Undetermined

Category X – Cannot assess harm at the time of error evaluation

Incidents of lasting harm or deaths attributable to medication error reported by the Hospitals are rare. The goal, as always, is to minimize medication errors that actually reach patients.

Responsibility for the safe prescription, dispensing and administration of medications in a hospital is shared. Physicians, Physicians' Assistants, and Nurse Practitioners are authorized to prescribe medications. Pharmacists are responsible for acquiring, storing, reviewing prescribed medications; compounding some medications; and providing medications to the floors. Nurses, and in some cases Physicians, are responsible for administering medications to patients. At each step in the process, medications and medication orders are reviewed to ensure patient safety.

III – PURPOSE

OBJECTIVES AND SCOPE

The objective of the investigation was to review existing inpatient medication use processes at four Los Angeles County Hospitals, identify areas that pose the greatest risks of medication error, and offer recommendations that would reduce that risk. The CGJ also sought best practices at each Hospital and at medical centers outside the County that should be adopted throughout the system.

The following Hospitals were reviewed:

Los Angeles County+USC Medical Center
Harbor-UCLA Medical Center
Rancho Los Amigos Rehabilitation Center
Olive View Medical Center

Harbor-King was not included in this review for several reasons. As the evaluation was being developed, there were only 25 beds in the hospital, and it was in transition from being independent to being managed by Harbor-UCLA.

The review included processes associated with prescription, dispensing, and administration of in-patient medications, and focused on risk of error, as contrasted with investigation of actual errors.

IV – INVESTIGATION

METHODOLOGY

The investigation included:

Review of documents, including processes, procedures, training and evaluation protocols, reports, and class specifications. Appendix B lists documents reviewed.

Interviews and site visits to all facilities. All four Hospitals hosted one-day site visits. Typical participation included management in charge of Nursing, Pharmacy, Operations, Administration, Information Technology, and Medical Services.

Development of flow charts. Existing flow charts were reviewed where available, and new charts for key processes at each Hospital were developed.

Identification of areas of risk. These areas, developed from the analysis of the data collected, were set forth and reviewed with DHS staff members for factual accuracy.

V – RESULTS OF THE INVESTIGATION

The CGJ wishes to acknowledge the cooperation, openness, and professionalism of DHS staff throughout this investigation. They were frank, responsive, and treated the investigation as an opportunity to improve their operations.

DHS is implementing a comprehensive program intended to apply best pharmacy and medication use practices to reduce as much as possible the risk of medication errors. In 2006, DHS reinstituted the position of Director, Pharmacy Services. The incumbent has been working

effectively with the Hospitals' Pharmacy Chiefs to implement new technology and develop policies and programs that reduce risk of medication errors. Although not complete in all Hospitals, the programs are considered by Hospital staff to be excellent tools in the overall drive to reduce medication errors.

CURRENT PHARMACEUTICAL AND RELATED MEDICAL PROCESSES

All Centers use the "5 Rights" standard – committing themselves to processes that ensure:

Right Patient – that medications are prescribed for and given to the intended patient

Right Medication – that medications are appropriate to the medical issue, they do not react to other medications, the patient is not allergic to the medication, and there are no counter-indications for its use

Right Dose – that the dosage and strength of the medication is appropriate and correctly calculated and administered

Right Path – that the means of administration (e.g., oral, intravenous) is correct

Right Time – that medications are administered at appropriate frequencies and when scheduled

The Centers use an interdisciplinary approach to ensure that medication errors are kept to a minimum. The Chief Medical Officer, the Chief Nursing Officer, and the Pharmacy Director at each facility jointly discuss and agree on recommendations to reduce medication risk, and are jointly implementing technology improvements to reduce the risk of medication errors. There is agreement that reducing risk of more serious medication errors requires:

Vigilance in reporting errors without patient impact (UHC PSN Category A – C), including a strong self-reporting practice

Responding to reported errors with training and process changes, where justified, in contrast to disciplinary actions

Trend analysis of patterns of errors to develop appropriate procedures in response to problems

The establishment and management of a standard system-wide formulary, or set of medications at all four Hospitals, has had a positive impact. This formulary is developed and maintained by the DHS Core Pharmacy and Therapeutics Committee with representation from all facilities. It reduces the risk of error by limiting the medications that are available for use. Therefore:

Medical and Pharmacy Staff are more likely to be familiar with the range of interactions and typical doses and can better predict potential complications

Nursing staff are familiar with standard means of administering medications

The Hospitals also have a strong commitment to ensure that all staff members are familiar with processes and procedures associated with reducing medication error. When trend analysis uncovers a repeated pattern of error, such as the inappropriate use of abbreviations or illegibility, the Chief Medical Officer is informed and reinforces the approved practice with all Physicians. Nurses must be re-certified each year, and tested in proper procedures and calculations. If a

Nurse has exhibited difficulty with some aspect of medication administration, that aspect is emphasized in his or her recertification training and testing.

Each Hospital has a slightly different process, and its medication error risk mitigation reflects those differences.

Tables 4 and 5 list the principal safety elements of medication administration that are in place at all Hospitals.

Table 4: Systemic Safety Reviews in Typical Administration of Medication

Systemic Steps
➢ Look alike/sound alike medications are stored in widely dispersed locations and are visibly labeled as such both in the pharmacy and in the units. This reduces cases of substituting incorrect medications that look or sound similar to the intended medications.
➢ High-risk medications, including all oncology medications, are checked twice by pharmacy and nursing.

Table 5: Safety Reviews in Typical Administration of Medication

Step	Primary Responsibility	Reviews/Safety Checks
Prescribing	The Physician[17] decides the medication needed for patients.	Pharmacist reviews for drug interaction, dose, duplication, allergies, and contra-indications for patients prior to dispensing. *Exception: In an emergency, the Physician can perform all steps without pre-review by pharmacy.*
	The Physician[2] writes prescription.	Nurse and Pharmacist reviews for legibility and absence of abbreviations before entering orders into system. There is zero-tolerance for illegible handwriting and unapproved abbreviations.
Dispensing	Pharmacist or Pharmacy Technician inputs prescription into Pharmacy System.	Pharmacist reviews for accuracy, safety, appropriateness.
	Pharmacist or Pharmacy Technician pulls medications and delivers medications to units.	Pharmacist reviews pulled medications for accuracy before they are released for delivery.
Administering	Nurse administers medications to patient.	Nurse double checks medications pulled against Medication Administration Record (MAR), which contains all medication orders issued for that patient. Nurse checks MARs to ensure that all medications changes are included.

[17] Note: Others may also prescribe medications, including a Physician Assistant or a Nurse Practitioner.

Step	Primary Responsibility	Reviews/Safety Checks
		For high-risk medications, second Nurse checks before administration. Patients are given manuals that encourage them to participate in ensuring medications are correct (e.g., pointing out when medications appear different).

To augment these standard practices, the Director, Pharmacy Services, with the support of the Pharmacy Chiefs at the Hospitals, has begun implementation of a plan that includes a manual of best practices, allocation of Pharmacist resources, and installation of technology systems that reduce medication error risk. This work includes the adoption of structured Physician order forms and other processes that require interdisciplinary teamwork. Table 6 outlines the technology used and best practices for the inpatient medication process.

Table 6: Implementation of Technology and Best Practices
Inpatient Medication Process

Medication Process	Technology	Status			
		LAC-USC	Harbor-UCLA	Olive View	RLA
Prescribing	Structured Physician Order Forms/Admission and Transfer	*Full*	*Full**	*Full*	*Full*
	CRM Pathways	*Full*	*Full*	*Full*	*Full*
Transcribing	Medication Order Scanning System	*Full*	*Full*	*In Process*	*In Process*
Dispensing	Pharmacy Information System	*Full*	*Full*	*Full*	*Full*
	Automated Dispensing Cabinets	*Full/ Profile*	*Partial/ No Profile*	*In Process*	*Full/ Profile*
	Medication Carousels	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*
	Pharmacy Barcode Prepackaging	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*
Administration	Nursing Bedside Barcode Med Administration	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*
	IV Smart Pumps	*Full*	*Planned/ Future*	*Planned/ Future*	*Planned/ Future*
Monitoring	Online Drug Information available on patient care units	*Full*	*Full*	*Full*	*Full*

	Unit-based Clinical Pharmacists	*Partial (ICU, Burn Pediatrics)*	*Partial (ICU, Pediatrics)*	*Planned*	*Partial*
	Emergency Department Pharmacists as part of patient care team	*Planned*	*Planned*	*Planned*	*No ER*

** Has best practice in requiring handwritten medications to be formatted in block lettering*

Legend:
Full – fully installed throughout all inpatient areas
Full Profile – ADC technology integrated with Pharmacy System
Partial – Partially installed throughout inpatient areas
In Process – Implementation in process
Planned/Future – Planned for installation at a future date

Table 7 outlines the safety implications of the technology and procedures.

Table 7: Safety Implications of Technology and Procedures

Technology	Description and Safety Implications
Structured Physician Order Forms/Admission and Transfer	Used at all facilities, these are pre-printed forms that are used by Physicians to order prescriptions. Standard medications and doses are pre-printed. In a best practice at Harbor-UCLA, the forms require block lettering to list prescriptions that are not pre-printed. These forms reduce the likelihood of misinterpretation when Pharmacy Technicians and Pharmacists enter the information into the Pharmacy System.
CRM Pathways	These are in place at all Hospitals. Also known as "Pathways," these are pre-defined courses of action associated with common illnesses and conditions. They spell out standard medications used to treat these conditions. By doing so, they reduce opportunities for inappropriate choices of medications and inappropriate dosages.
Medication Order Scanning System	This system eliminates the need for faxing medications orders to the Pharmacy, simplifies the entry process into the Pharmacy System, and permits faster and more consistent communication between the Pharmacy and the floors regarding Pharmacist interventions.
Pharmacy Information System	All medications that are prescribed for every patient are managed through this system, which is the source of daily MAR print outs.
Automated Medication Dispensing Cabinets	When implemented, ADCs are the source of approximately 70% to 90% of medications given to patients. Typically, a Nurse uses a fingerprint and a password to sign on, and requests medications for a specific patient. When integrated with the pharmacy system (Profile), drawers with specific medications are opened only after the Pharmacist approves the order. Before integration, the Nurse specifies medications for the patient from the MAR, and a drawer with that medication opens. This improves recordkeeping, and reduces the risk of error in selecting medications, in selecting medications before they have been approved, and in selecting medications when they are not due.

Technology	Description and Safety Implications
IV Smart Pumps	The smart pump's "brain" consists of customized software that contains a drug library. This software essentially transforms a conventional IV pump into a computer that issues an alert. The alert indicates that a Nurse has programmed an infusion that falls outside of a particular medication's recommended parameters, such as dose, dosing unit (mcg/kg/min, units/hr, etc.), rate, or concentration. These are sometimes called "safety rails." Smart pumps log data about all such alerts, including the time, date, drug, concentration, programmed rate, and volume infused, thus providing valuable continuous quality improvement (CQI) information. In addition, as required by Joint Commission, formerly known as the Joint Commission on Accreditation of Health Care Organizations (JCAHO), all smart pumps have free-flow protection—safety features that are designed to prevent unintentional overdoses of medication or fluid. Smart pumps may also be used to administer patient-controlled analgesia.
Medication Carousels	Bar-coding medications eliminate look alike/sound alike errors. In the ultimate use of barcode technology, a patient and the Nurse wear barcode bracelets. At time of administering medications, the Nurse scans the patient's barcode bracelet; his/her own barcode bracelet, and the barcode on the medications being administered. This three-way barcode scanning tracks and helps to ensure the "5 rights" – patient, medication, pathway, dosage, and time. Medication Carousels automate the distribution of medications and supplies for Hospital pharmacies by providing an automatic storage and retrieval system. It offers bar code labeling and storage for both bulk and unit-dose medications.
Pharmacy Barcode Prepackaging	
Nursing Bedside Barcode Med Administration	
Online drug information available on patient care units	This system provides information on all medications, including allergic reactions, contra-indications and dosing, providing improved information on medication issues before orders are placed, and allowing Nurses to check issues associated with administration of medications.
Unit-based Clinical Pharmacists, and Emergency Pharmacists as part of Patient Care teams	Clinical and Emergency Pharmacists provide drug information, recommend dosage adjustments, respond to questions from practitioners and nursing staff, and make ongoing suggestions regarding drug therapy. This provides another source of immediate support for clinicians, as well as immediate review and validation of medication orders. Assignment of Clinical Pharmacists to high-risk treatment areas and emergency rooms lowers the risk of medication error and raises the overall quality of care to patients.

In addition, DHS is beginning to plan for system-wide Electronic Health Records (EHRs) for their patients. EHRs are a pre-requisite for more comprehensive computerized systems that will reduce the risk of medication errors.

VI – FINDINGS AND RECOMMENDATIONS

ORGANIZATION

Finding 1: DHS central staff Directors have established spheres of influence when working with the Hospitals, but they lack formal authority relationships and audit functions

Current relationships are built on trust and collegiality and judicious use of staff authority. The authority has not encompassed all the oversight provisions included in the Job Specification for the Director, Pharmacy Services. The Director, Pharmacy Services, reports to the Departmental Chief Medical Officer. The Director, Pharmacy Services, participates in and provides staff support for major committees, including the DHS Core Pharmacy and Therapeutics Committee, the DHS Pharmacy Director's Committee, and the DHS Pharmacy Information Systems Committee. The incumbent has been effective in funding and generating agreement about implementation of new technology. This assignment of responsibility and chain of command through the Chief Medical Officer appropriately reflects the need for central direction for the Hospitals.

Nevertheless, the Hospitals do not share the full reports of all Medication Errors, which are essential for the Director to understand overall Pharmacy Performance and needed interventions. In addition, there is no formally developed Audit Schedule to review conformance with Departmental policies associated with ordering, distributing, and administering medication.

Recommendation 1: The Director, Pharmacy Services, should be entrusted with the authority to carry out medication error risk and performance audits and business process reviews.

Given the level of human risk and dollars involved, DHS requires a centralized approach to auditing medication errors and processes. These reviews should be coordinated with the Department of Auditing and Compliance. To avoid any potential conflict of interest, Audit staff must have direct access to the DHS top management, up to the Director, DHS. In addition, copies of the audit recommendations should be given to the Director, DHS. Audit recommendations should include proposals for standardization and process improvements in all medication-related functions. The Director, Pharmacy Services, should establish these functions as formal, centralized responsibilities. Along with the audit responsibilities should be an established schedule for performing process and performance audits annually at each Hospital. While this function will require additional staff, process improvements and technological enhancements should cover the costs of this function.

In addition, the Director, Pharmacy Services, should have access to all medication error reports. Recommendation 9 elaborates on process changes required to implement changes to sharing these reports.

TECHNOLOGY

Finding 2: Investments in technology can result in significant reductions in medication error risks.

Automated medication dispensing cabinets have proven themselves to be a good, if substantial, investment. Where they have been put into use, Hospital staff members report that errors have fallen, and the dispensing process has become more efficient. Similar results are projected for pharmacy medication carousels. Bar coding systems offer the prospect of a new level of patient medication safety that has heretofore been unavailable. A pre-requisite for the success of these systems is the implementation of standards for bar code systems across the industry.

IV Smart Pumps also add a new level of medication error reduction by highlighting delivery rates or concentrations that fall outside standard parameters. Smart Pumps allow for programming of standard concentrations of IV medications, removing the burden of the unit nursing staff having to calculate flow rates, thereby eliminating an additional potential source of error**.**

The implementation of new technology has rendered information technology staff ever more vital to Hospital operations. The medication use systems assessed here are highly dependent on contractors and internal staff members for installation, staff training, and system maintenance. The systems are expanding in both scope and complexity.

DHS is aware of this issue. DHS's Chief Information Officer (CIO) has prepared a business plan that outlines the resource needs he expects to face immediately and for several years into the future. Work remains to gain the funding needed to offer competitive salaries and deploy staff at the Hospitals.

Recommendation 2: DHS should invest in medication management technology improvements, using life cycle costing that accounts for acquisition, installation, and maintenance of equipment. Funding for these investments should be drawn in part from medication cost savings such as those attributable to improved acquisition management.

The Technology plan being implemented deserves full funding. Major technology improvements to be implemented include:

IV Smart Pumps at all facilities
Complete implementation of Automated Dispensing Cabinets at all Hospitals
Integration of the ADC system with the Pharmacy System
Medication Barcode Carousels
Pharmacy Barcode Prepackaging
Electronic Health Records

While these systems are expensive, it is a prudent decision to implement them. County staff members are proud of their efforts to improve patient safety, and investments in technology reinforce the County's commitment to their efforts. Furthermore, the County's investment in best practices in patient safety will help prevent harm to patients, and are evidence of sincere interest in the event of litigation.

In calculating the total costs of the system, DHS should employ the best practice of life-cycle cost accounting, which provides resources for operation and maintenance for the equipment during its life and for replacement when its useful life is completed. It is especially important when acquiring the equipment to ensure that there is sufficient staffing to program and test before implementing, because medical staff depend on the accuracy of the information and technology systems.

The Director, Pharmacy Services, has been vigilant in keeping down the costs of medication. Last year, by negotiating carefully with the primary medication wholesaler and instituting prudent cost saving programs, savings of more than $150,000 each month have been realized. Careful attention to Formulary management has also led to using cost-effective medications. After years of escalating medication costs, in Fiscal Year 2006/2007 DHS is projected to avoid more than $6 million in pharmaceutical costs, devoting a significant portion of these savings to technology improvements. The ability to apply savings to further improvements is a positive incentive and should continue.

Finding 3: Olive View Medical Center processes appear to be incompatible with realization of ADC benefits.

Olive View's description of its plans to install ADCs is not consistent with the approaches used by other Hospitals. Its current systems include pneumatic tube distribution of medications. Citing space limitations on the floors, Olive View staff members are designing plans that limit access to the ADCs, which limits its advantage of allowing nursing staff complete access to regular medications while maintaining controls over controlled substances.

During the site visit to Olive View, it was not conclusively demonstrated that patients' identities are always recorded on medical records before medical orders are written. There was some evidence that the patient's last name was being written by hand on the initial order sets and then covered with a printed label. This is not a best practice, and it affords a clear opportunity for medication error, as it is possible for the order to refer to the wrong patient. When questioned about the practice, Olive View staff denied that this was the case. The denial, in fact, is more disturbing than the practice itself, since it suggests a defensiveness that could cover other errors or weaknesses.

A single site visit should not be considered conclusive, and is not in itself sufficient grounds for action. It is, however, sufficient to support a review of current medication orders, dispensing, and administration to ensure that the Hospital is fully prepared to implement a more automated pharmacy system.

Recommendation 3: As part of the implementation of ADCs at Olive View, DHS should review the complete medication order, delivery, and administration process to ensure that both the baseline process and the plan to strengthen it with ADC technology are sound.

As stated in the finding supporting this recommendation, it is not clear that the processes at Olive View are as strong as those in place at sister County Hospitals. It is an axiom of technology implementation that, if the underlying processes are not completely sound, the application of technology may well make matters worse rather than better. As part of the implementation of the ADC System, the in-patient medication processes at Olive View, from prescription through

ordering, dispensing, and administration should be subject to a thorough peer review. This peer review should:

Redesign processes as necessary
Ensure that Olive View has adopted best practices used elsewhere in the County
Establish processes that ensure low levels of medication error are in place and in practice.

Finding 4: Electronic Health Records (EHRs) and Computerized Physician Order Entry, when properly implemented, are best practices to reduce medication error.

Computerized Physician Order Entry (CPOE) has been successfully implemented in several regional hospitals. It is difficult and expensive to do. It requires extensive planning, a significant investment, and careful building of internal acceptance. Executive management must make the commitment to CPOE and consistently let people know that it will be implemented – especially when thorny issues arise or the system shows difficult growing pains. A pre-requisite for its success is the implementation of EHRs, which are currently being planned in DHR.
CPOE, difficult as it is to implement, is worth the trouble. It eliminates a transcription step that generates errors. It eliminates illegible orders and unapproved abbreviations. Wrong dose and wrong drug errors are reduced. Data can be easily collected for evidence-based clinical paths, considered a best practice. Physician orders, including medication orders, can be transmitted to the responsible parties instantly. Medical records can be shared between facilities and programs, making it much faster and easier to assess patients accurately, and all but eliminating the "shopping" of medical services by patients. Productivity, quality of care, and patient safety all advance.

DHS has been wise in the order of technology implementation. The technologies described in this report are well-proven innovations that impact patient safety. After the installation of Automated Pharmacy Systems, assignment of Clinical Pharmacists, acquisition of IV Smart Pumps and bar coding of medications are complete, EHRs and CPOE appear to be the next major steps in reducing the risk of medication errors.

Recommendation 4: DHS should begin now to plan for the implementation of CPOE and EHRs.

DHS should convene an inter-disciplinary team charged with: a) researching current technology, b) developing specifications and cost estimates, and c) designing implementation plans for CPOE systems that will one day serve all County medical facilities. The team should set milestones to complete research, identify preferred technologies, address implementation issues, identify offsetting savings, and submit budget requests.

This is a multi-year, multi-million dollar effort. There may be physician resistance within the Hospitals that needs to be addressed and overcome. There will also be training and retraining issues. There are several interim steps that are being taken that will support the development of DHS-wide systems. Currently, Lab Directors are standardizing nomenclature across the Department for common tests in anticipation of the need to be able to share test results for a patient that visits multiple hospitals.

PEOPLE

Finding 5: Clinical Pharmacists are effective in reducing medication error risks.

Clinical Pharmacists spend time as part of patient care teams, consulting with Physicians and the remainder of the team on the units and during rounds. They provide drug information, recommend dosage adjustments, respond to questions from nursing staff, and make suggestions regarding initiation of drug therapy.

All of these activities relieve stress on the Physicians and other clinicians who must sometimes make rapid decisions about patient care in difficult circumstances. This improves the quality and speed of the decisions and reduces the likelihood of medication errors.

Recommendation 5.0: DHS should expand the number of Clinical Pharmacists, institute a Clinical Coordinator position at each Hospital, and use Tech-Check-Tech processes to free Pharmacists to perform other pharmaceutical duties

Recommendation 5.1: DHS should increase Clinical Pharmacist staffing in Hospitals, targeting certain high-risk environments.

Clinical Pharmacists are most useful in units where:

Complex medication combinations are used (e.g., oncology).

Rapid response to patient conditions often prevents traditional Pharmacist pre-review of medication orders (e.g., ICU, OR, and ER).

LAC+USC has already deployed Clinical Pharmacists in ICU, Pediatrics and the Burn units. RLA and Harbor-UCLA also use Clinical Pharmacists. Those assignments should be continued and expanded wherever staff resources can be found. One possible strategy to accomplish this is to use the labor savings claimed for pharmacy automation systems and a best practice called Technician Checking Technician (called Tech-Check-Tech) and discussed further in Recommendation 5.4 to provide more time for clinical pharmacy support. These positions can be key steps into a Pharmacy Career Ladder, and will make the County positions more attractive, helping with recruitment of Pharmacists.

Recommendation 5.2: DHS should establish a Clinical Coordinator at each Hospital to manage Clinical Pharmacists.

To maximize the effectiveness of Clinical Pharmacists, Clinical Coordinators should be hired. These staff members will develop job specifications, draft job descriptions, identify training needs, and develop systems and procedures to maximize the effectiveness of Clinical Pharmacists. They will also establish priorities regarding the assignment of Clinical Pharmacists in treatment units.

Recommendation 5.3: DHS should allocate additional funding to training programs to provide ongoing education and development of Clinical Pharmacists.

DHS facilities provide facility-based training at each hospital. In addition, Pharmacy Managers and staff attend State and national Pharmacy Conferences. Clinical Pharmacists require

enhanced skills in verbal and written communication and expertise in medications used by their assigned units. The Department should emphasize training for Pharmacists in addition to the 15 hours of paid time off allowed by DHS for continuing education and the facility based training programs. Formularies change as new medications are introduced and new uses are found for existing drugs. Clinical studies identify risks heretofore unknown, or call into question the claims of efficacy proffered by drug manufacturers. Root cause investigations uncover weaknesses in accepted safety procedures that require process changes. Other hospitals, both within the County and elsewhere, develop new and more effective pharmacy practices. All of these developments need to be disseminated to DHS Pharmacists so that they remain at the forefront of the profession, and so they offer to their colleagues and patients the highest quality medical care possible. Training will offer Pharmacists the opportunity to network with their peers and learn additional approaches and best practices used at other medical centers.

Recommendation 5.4: DHS should consider using Tech-Check-Tech processes to free Pharmacist resources.

The California Board of Pharmacy permits this process when hospitals implement Clinical Pharmacist services. In this process, Technicians (instead of Pharmacists) check 24-hour medication carts from orders that are unchanged from the previous day. This practice releases time for Pharmacists to provide more effective interventions and may free time for more clinical work. DHS's Hospitals have recently increased the required professional qualifications for new Pharmacy Technicians. They now require Pharmacy Technician Certification Board (PTCB) certification of new staff members. This improvement will ultimately support increased responsibility for Technicians, including Tech-Check-Tech procedures.

Finding 6: 24-hour Pharmacist coverage is important to Patient Safety.

A Pharmacist is needed on-site for in-patient care on a 24/7 basis, particularly for acute patients. If a Pharmacist is not available, a comparatively slow and cumbersome process of faxes and telephone calls to Pharmacists at home is required. A "night locker" must be maintained, under the control of a Senior Nurse. If a medication is needed that is not in the night locker, a Pharmacist must be called in from home to open the main pharmacy and dispense it. The primary disadvantage of the process is that it is not fast, and the circumstances that give rise to overnight medication orders are likely to demand prompt action. There are also evident weaknesses in the processes for the checking of medications against orders. Finally, tired Pharmacists are expected to perform their day shifts, even when their sleep is interrupted. In all professions, errors usually increase when people become sleep-deprived.

Some smaller hospitals cannot support a 24-hour pharmacy. These hospitals are adopting the capabilities of automated prescription transmission, which involves scanning medication orders to a Pharmacist for verification and approval. The Pharmacist can then release the medication from the ADC at the smaller facility.

Recommendation 6: DHS should immediately establish a 24-hour Pharmacy at Olive View Medical Center, and monitor Rancho Los Amigos Rehabilitation Center off-hours demands for medication.

Olive View Medical Center is of sufficient size and structure to warrant a 24-hour pharmacy. While they recognize the advantages of 24/7 coverage, staff at Olive View cite the difficulty of hiring Pharmacists to work this demanding shift. It is a hurdle to be overcome rather than an insurmountable obstacle, and Olive View should work with Department of Human Resources staff to develop incentives sufficient to attract night shift pharmacists or retain pharmacists when night shifts become a requirement. Olive View is too far removed from other medical facilities to seriously consider a partnering solution. Its patient census and the existence of an emergency room indicate that there is sufficient demand for constant staffing.

Rancho Los Amigos, as a rehabilitation facility, has a different patient profile, and has historically seen fewer demands for after-hours pharmacy. This may be changing. DHS should monitor off-hours pharmacy demands on a regular basis, and consider partnering with other DHS facilities or other plans to ensure coverage.

Finding 7: It is a common practice to conduct pre-employment drug testing among staff involved in the health care professions. DHS does not do this.

Drug screening and random drug testing are common means of ensuring security and safety in a wide variety of sensitive business and government operations. A number of hospitals use them. Failure to conduct screening and testing exposes patients to a potential risk of not receiving prescribed medication (if an addicted employee substitutes a placebo for the particular drug), and increases the potential risk of medication errors when impaired staff members prescribe, approve, distribute, and administer medications. This is a known risk in an environment where staff members sometimes work long hours, and where there is ample knowledge of the "right" mix of drugs to take to stay alert.

Recommendation 7: The County should implement pre-employment drug screening and should develop a targeted program to provide for early identification and treatment of substance abuse among staff with access to controlled medications

Pre-employment screening will reduce the risk of hiring individuals who are addicted to narcotics or other drugs. In addition, a program should be developed, modeled on best practices, that include training managers to recognize problems associated with drug abuse, referrals to Employee Assistance Programs, development of reporting mechanisms that identify patterns of abuse, and testing for drugs with a lower threshold of evidence than for other County staff. The program should be modeled on best practices which provide for confidentiality of results, automatic retesting of positive results, counseling, and, where needed, recovery programs. This program is not, at heart, different from ensuring that medical staff members do not have chronic infectious diseases.

Finding 8: A "Safe and Just" culture is essential to accurate reporting of errors – including medication errors – as well as to the rapid and effective response to error trends.

A survey undertaken by DHS in December 2005 showed disturbingly high levels of concern among both Nurses and attending Physicians that errors would be held against them. Nurses also expressed high levels of concern that errors would be kept in their personnel files. Some of this concern may be traced to a long-standing policy in which managers close out reports of all types of medication errors by indicating that an employee was "counseled about the incident". That is the first step in the County's standard progressive discipline process. In that process, managers are advised to keep a permanent record of the counseling action for use as needed in ensuing sanctions for further errors.

In April 2006, DHS engaged a contractor to deliver a training workshop, entitled "Patient Safety and the Just Culture". It appears to have been intended to address the issue of a punitive culture by advocating a culture in which acknowledgement that errors are human and inevitable is balanced by a strong sense of professionalism and "zero tolerance" for medication errors. Before punitive actions are taken when a rule is broken or mistake is made, a Just Culture would consider:

- Whether the employee knowingly violated the rule
- Whether there was a compelling reason to violate the rule
- Whether the employee had a good faith but mistaken belief that the violation was justified or insignificant
- Whether the source of the error resided within the system or was behavioral.

Based on answers to such questions, the response would vary from counseling to training to revising procedures.

Perceptions of an unjust culture are crippling to any attempt to encourage the self-reporting of Category A, B and C errors, in which no measurable harm comes to a patient. If Physicians and Nurses fear retribution, they will be significantly less likely to self-report errors that have little measurable impact. DHS's efforts to counter them are laudable, but it seems likely that they have not been sufficient. Further surveys were not available, but anecdotal evidence suggests that negative perceptions have proved to be persistent.

Recommendation 8.0: DHS should strengthen its "Safe and Just" culture.

Recommendation 8.1: DHS should build on past efforts to establish a "Safe and Just" culture within DHS facilities.

DHS should embark on a number of initiatives to reinforce a "Safe and Just" culture at the Hospitals by:

Providing additional training and coaching, and if necessary find a job reassignment where staff unable to comply with policies can function effectively

Ensuring that senior executives understand and support the effort

Publicizing examples where errors that did not severely affect patients were treated with education and process change, rather than with disciplinary action.

Recommendation 8.2: DHS should work with the County's Department of Human Resources (DHR) to build a consensus that training and process change are more effective than disciplinary action.

DHS should work with DHR to gain agreement that staff members who opt to self-report will not themselves be disciplined.

PROCESS

Finding 9: There is insufficient consistent, Department-wide medication error trend analysis.

The identification of trends within overall medication error rates is key to reducing them. The Hospitals do some analysis now, although they do not all follow the same guidelines; and their analysis appears to be limited at times by a lack of formal training for some Hospital Risk Management staff members. For the past year-and-a-half, data have been gathered in a nationwide system run by the University HealthSystem Consortium, which permits sophisticated analysis of errors. There has been insufficient consistent reporting and analysis to take advantage of that capability. While some errors occur only within one Hospital, others may be related to overall policies, training regimens, or technology systems across the County. These error trends should be identified and corrected; this can only be done if errors are reported and analyzed consistently across the County. In addition, such a function will serve to protect the Hospitals against the possibility that a medication error trend may be missed at the Hospital level.

Recently, DHS has developed a "Report Card" which tracks high level trend data. It is a good beginning, but needs additional development.

Recommendation 9.0: DHS should analyze medication error trends, share aggregated information with Departmental and Facility leadership, and allow central review of medication error reports.

Recommendation 9.1: DHS should analyze trends in medication errors regularly and Department-wide.

While it is important to continue Hospital level error reporting and analysis, the Departmental Risk Officer can serve to enhance the effectiveness of Hospital Risk Management much in the way the Director, Pharmacy Services, has supported and enhanced the delivery of excellent Pharmacy Services.

Consideration should be given to monthly distribution of standardized reports, which should be developed in consultation with DHS's Nursing, Pharmacy, and Medical Officers. Consistency across DHS for certain reports is important, and will provide essential baseline information to place both errors and mitigation programs in perspective. These reports should be made available to all Hospital-based Nursing Officers and Pharmacy Directors, so they can learn from events that occur at the other facilities.

Most staff members in the Hospital Risk Management units are trained medical personnel. They should employ or partner with statistical researchers and skilled computer analysts with database experience to develop standard reports and design ongoing trend analyses.

Recommendation 9.2: DHS should provide access to full reports on medication errors at all Hospitals to the Director, Pharmacy Services and the Departmental Chief Nursing Officer.

The Director, Pharmacy Services, is responsible for promoting safe medication use practices. She is authorized to have access to confidential medical information. She must be able to assess and evaluate current medication error risks, so that she can establish programs to reduce those risks. On this basis, the Director, Pharmacy, should have access to full reports on medication errors.

Finding 10: The number of errors in UHC-PSN Categories A-C is less than expected, and raises the possibility that they are not fully self-reported.

A review of reported errors shows few reported errors in the A and B1 categories for all four Hospitals in the six months ending March 31, 2007. The total errors reported for "no patient harm" categories (A, B1, B2, C) were low, considering there were over 300,000 patient days at Harbor-UCLA, Olive View, and RLA, where many patients have multiple medications. Given the number of reported errors in other categories over the same period, this does not appear logical. It is understandable that staff members who make lower category errors are sometimes reluctant to report them. Even in a non-punitive atmosphere, it is easy to see that a staff member would be reluctant to report a minor mishap, such as picking up an improper medication from a shelf, noticing it immediately, and replacing it before gathering up a proper medication. This is how major trends are identified that lead to, for example, separating look alike/sound alike medications. For errors in Categories B1 and B2, the patient receives no improper medications. Self-reporting is the only source of data. Responsible staff noted that the system used to track medication errors and pharmacy interventions is very cumbersome to use, further discouraging reporting of errors. This possible underreporting is important, because identifying errors that do not result in patient harm can point the way to weaknesses in the system that pose the potential for more serious adverse events.

Recommendation 10: DHS should consider establishing Nurse "Naïve Observation" auditing to reduce dependency on self-reporting for medication errors.

In this practice, at random intervals Nurses observe other Nurses administering medications. Afterwards, the observing Nurse checks the Medical Administration Record (MAR) and patient records to determine whether any errors were made. A 2002 study comparing methods of detecting medication errors found independent observation by Nurses to be the most efficient and accurate method of doing so.[18]

[18] "Comparison of methods for detecting medication errors in 36 hospitals and skilled-nursing facilities" American Journal of Health-System Pharmacy, Vol 59

Finding 11: DHS does not have a regular practice of replicating the best practices implemented from one facility to another.

As an example, Harbor-UCLA has implemented Structured Physician Order Forms for admissions and transfers requiring the use of block lettering to reduce cases of illegibility. These forms significantly reduce a broad range of medication order errors, including illegible orders, unapproved abbreviations, dosage errors, and "wrong drug" errors. The Structured Physician Order Forms are considered successful where they are now used. The balance of DHS facilities does not use block lettering on these forms. As another example, Olive View does not recognize the same medications as high risk as the other Hospitals.

These are examples of processes that are low-cost and can be relatively easily implemented, as contrasted with implementation of ADCs and bar coding technology.

Recommendation 11: DHS should recognize best practices implemented at one facility, and replicate them system-wide.

The best practice of Structured Physician Order Forms with block lettering spaces, currently in place at Harbor/UCLA Medical Center, should be implemented at all County Hospitals. Introducing these forms system-wide is a low-cost and low-risk item for DHS. In addition, if one or more Hospitals identify a certain medication as high risk, all Hospitals should similarly categorize that medication as high risk absent a compelling reason to the contrary.

Successful best practice programs often include regular reporting on best practices at senior staff meetings, and development of tracking mechanisms for implementation of the changes.

CONCLUSION

The 2006-2007 Los Angeles County Grand Jury found that the Department of Health Services has made notable strides in strengthening the control over pharmacy distribution of medications.

Implementations include a system wide formulary, new medication ordering and dispensing technology, and the introduction of a number of best practice processes.

AT the same time, the ongoing concern of eliminating medication-processing errors requires that DHS continue such efforts in the areas of organization, system development, enhanced review, and the expanded use of Clinical Pharmacists, a Clinical Coordinator, and the Tech-Check-Tech process.

APPENDIX A – ACRONYMS

ADC	Automated Dispensing Cabinets
CGJ	Civil Grand Jury
CPOE	Computerized Physician Order Entry
CRM	Clinical Resource Management
DHS	Department of Health Services (Los Angeles County)
EHR	Electronic Health Records
Harbor-UCLA	Harbor-UCLA Medical Center
JCAHO	Joint Commission on Accreditation of Health Care Organizations (Currently referred to as "Joint Commission")
LAC+USC	Los Angeles County + University of Southern California
MAR	Medical Administration Record
MD	Medical Doctor (referred to as Physician in this report)
NP	Nurse Practitioner
Olive View	Olive View Medical Center
PTCB	Pharmacy Technician Certification Board
PA	Physician's Assistant
RLA	Rancho Los Amigos Rehabilitation Center
UHC PSN	University HealthSystem Consortium – the Patient Safety Net

APPENDIX B – DOCUMENTS REVIEWED

1. Patient and Family Handbook; Rancho Los Amigos
2. Rancho Los Amigos National Rehabilitation Center Quality Resource Management Department; Summary Report on Medication Error Related Events, February 2007
3. Inpatient Pharmacist Interventions; March 2007
4. Rancho Los Amigos National Rehabilitation Center Quality Resource Management Department; Medication Errors Reported per 1,000 Doses Dispensed August 2003 – February 2007
5. Rancho Los Amigos National Rehabilitation Center Quality Resource Management Department; Medication Errors and Near Miss Events per 1,000 Medications Dispensed; February 2004 – February 2007
6. Rancho Los Amigos Orientation Schedule – 3 Week RN/LVN; Department of Nursing
7. Rancho Los Amigos National Rehabilitation Center; Department of Nursing; Orientation Schedule (Traveler)
8. Rancho Los Amigos National Rehabilitation Center; Orientation Module; Medication Administration
9. Rancho Los Amigos National Rehabilitation Center; RN/LVN Medication Administration Orientation Module; Handouts
10. Rancho Los Amigos National Rehabilitation Center; Generic Orientation Checklist - RN/LVN
11. Rancho Los Amigos National Rehabilitation Center; Medication Calculation Exercises
12. Patient Safety and the Just Culture: County of Los Angeles DHS
13. Rancho Los Amigos New RN/ LVN Graduate Program Outline (for re-entry nurses and new graduates
14. Rancho Los Amigos National Rehabilitation Center; Job Description for Staff/Relief Nurse
15. Rancho Los Amigos National Rehabilitation Center; Department of Nursing Administrative Policy and Procedure:
    a. Orientation: Nursing
    b. Competency Program: Management and Assessment, Initial and Ongoing
    c. Medication Management Guidelines
    d. Medication Administration Documentation
    e. Order Transcription, Recopying of Flow Sheets and Verification of Medication Administration Record
    f. Supplemental Blood Glucose Medication and Treatment Record
    g. Pyxis System Access and Responsibility
    h. Medication Error and Near Miss Reporting
    i. Competency Program: Management and Assessment, Initial and Ongoing
    j. Intravenous Therapy: Guidelines for Administration
    k. Waived testing
16. UHC Patient Safety Net On-Site Administration Report – Rancho Los Amigos Sample pie chart Report of Harm Score Distribution and Event Sub-type Distribution
17. PowerPoint Presentation – In-Patient Unit Nursing Orientation Program on Medication Management

18. Harbor/UCLA Medical Center Department of Nursing Productivity Report; April 2007 with Staffing Levels by unit
19. Olive View Medical Center Department of Nursing Productivity Report; April 2007 with Staffing Levels by unit
20. LAC+USC Medical Center Department of Nursing Productivity Report; April 2007 with Staffing Levels by unit
21. LA County DHS - Nursing Registry Usage FY 2007-07
    a. Harbor UCLA
    b. Rancho Los Amigos
    c. LAC+USC
    d. Olive View
22. Rancho Los Amigos Rehabilitation Center Department of Nursing Productivity Report; April 2007 with Staffing Levels by unit
23. Overview: DHS Medication Events October 2006 – March 2007 – PowerPoint Presentation
24. Proposed Medication Management Automation Solution, LA DHS 1/2007
25. Medication Safety: The Basics: PowerPoint Presentation from Amy Gutierrez
26. Pharmacy Utilization Report for FY 2006-2007
27. DHS Outpatient Pharmacy Automation Installation Plan: Expected Order of Installation Status – May 2007
28. The Just Culture Algorithm
29. "Medication Errors – A Nurse's Worst Nightmare" Working Nurse Magazine, April 9-30, 2007
30. "Med Errors = Bad Outcomes", Nurse Week, April 2007
31. Institute for Safe Medication Practices: Medication Safety Alert; Survey on High Alert Medications; May 17, 2007
32. LAC+USC Health Care Network Quality Management PowerPoint – Review of the Chemotherapy Medication Use Process
33. Managing Medication Related Events: PowerPoint Presentation
34. Medication Management Process in Valley Care – PowerPoint Presentation
35. LAC+USC Chemotherapy Physicians Orders
36. LAC+USC Daily Physicians Orders – Adult Critical Care
37. LAC+USC Neonate Continuous Infusion Orders
38. LAC+USC Neonate Continuous Infusion Recipes
39. LAC+USC Adult Insulin Continuous Infusion for Hyperglycemia in Critical Patients
40. LAC+USC Adult Inpatient Rasburicase Physician Order Form
41. LAC+USC Pharmacy Department Policy and Procedure Manual
    a. Inpatient Prescribing/Ordering General Practices
42. LAC+USC Department of Nursing Services Policy
    a. Medication Administration System
    b. High Alert Medications
    c. General Medication Policies
43. LAC+USC HealthCare Network Policy: Medication Usage
44. LAC+USC Adverse Drug Reaction & Medication Event Information Flow Diagram
45. List of High-Alert Medications
46. List of Look-Alike Sound-Alike Drugs

47. LAC+USC Drug Bulletin June 2006
48. Medication Reconciliation: JCAHO's National Patient Safety Goal and Sentinel Event Alert 1/06 PowerPoint Presentation
49. Intervention Summary Report
50. Harbor-UCLA – Patient Safety Bulletin October/November 2006
51. Harbor-UCLA – Patient Safety Bulletin July/August 2006
52. Harbor-UCLA – Patient Safety Bulletin May/June 2006
53. Harbor-UCLA – Patient Safety Bulletin January/February 2004
54. Harbor-UCLA – Patient Safety Bulletin November/December 2003
55. Harbor-UCLA – Patient Safety Bulletin October 2003
56. Los Angeles County DHS Pamphlet – Adult Dyslipidemia Formulary Pocket Guide 20063
57. Los Angeles County DHS Lipid Management Algorithm
58. Journal on Quality and Patient Safety – Volume 32, #2; February 2006: "How Many Hospital Pharmacy Medication Dispensing Errors go Undetected?
59. Wikepedia: Medical Error
60. JCAHO – Identifying Risks I the Medication Use Process – Strategies for Pharmacists
61. JCAHO Front Line – Admitting Pharmacists usher in big improvements
62. UHC Patient Safety Net Categories
    a. Pharmacist Review
    b. Medication Error Event Details Questions
    c. Adverse Drug Reaction Event Details Questions
    d. Event Type
63. Harbor-UCLA MAR Sample
64. Harbor-UCLA Adult Medical Admission Orders Sample – Blank
65. Harbor-UCLA Adult Medical Admission Orders Sample – Completed
66. LA County DHS Adult Inpatient Anticoagulation Physician's Orders
67. Medication Administration Guidelines: Table of Drugs: Standard IV Medications
68. Medication Administration Guidelines: Table of Drugs: Standard IV Medications (Chemotherapy Drugs)
69. Flow Chart: Medication-use Process for Hospital and Long-Term Care
70. Unlabeled Articles/Chapters
    a. Medication Errors: Prevention Strategies
    b. Action Agenda for Health Care Organizations
    c. Medication Errors: Incidence Rates
71. Harbor-UCLA Department of Pharmacy Process Flows: Current State as of Thursday, March 16, 2006
72. American Journal of Health-System Pharmacy, Vol 59 "Comparison of methods for detecting medication errors in 36 hospitals and skilled-nursing facilities"
73. Order of Adoption: Board of Pharmacy California Code of Regulations Change to Title 16, Division 17: Requirements for Pharmacies Employing Pharmacy Technicians
74. American Journal of Health-System Pharmacy, Vol 64 "Documentation of Pharmacists' Interventions in an Emergency Department and Associated Cost Avoidance
75. LA County DHS Class Specification; Director of Pharmacy Services
76. DHS Clinical Pharmacy Strategic Plan – July 2006 Final
77. Draft DHS Decision Grid: Pharmaceutical Procurement

78. DHS Pharmacy Leadership Program description
79. DHS Outpatient Report Card: Medication Use Performance Metric 2007
80. DHS Pharmacy Leadership Program proposal
81. DHS Report Card: Medication Use Performance Metrics 2007

Juvenile Custodies

Are We Paying Twice?

Cross Over Committee

Sandra Lee Mohr, Chair

Hannah Margolis
Marlene Markheim
John Visser

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

JUVENILE CUSTODIES - ARE WE PAYING TWICE?

EXECUTIVE SUMMARY

State law requires that whenever a minor is in custody in a juvenile hall or other county juvenile facility for thirty consecutive days, the county welfare agency needs to be informed. The law requires that the welfare department determine whether these minors are part of a family receiving cash aid benefits and, if so, make reductions in the family's aid payments to reflect the period of time the minor received care in the facility. Yet, there appears to be no liaisons between these agencies to share information and to stop the cash aid.

The Los Angeles County Probation Department handles over 20,000 custodies annually with a staff of 5,800 and budget of $630 million. Costs of an individual minor in custody are approaching $200 a day. The Department does a financial screening of the parents or other responsible relative and bills for the cost of care. If the family is receiving financial assistance, the family is not billed; this information should be sent to the welfare agencies.

The welfare agencies in Los Angeles County are the Department of Public Social Services and the Department of Children and Family Services. DPSS has over a million clients and over 13,000 employees. There is no direct supervision of the individuals receiving the cash aid and the agency relies on self reporting to find out when a child is no longer residing in the home. DCFS monitors families directly and should have knowledge of where a child is residing. Recent legislation prohibits simultaneous or duplicative case management or services provided by the county probation department and the child welfare services department.

The recommendations are designed to co-ordinate county agencies so that they will be in compliance with state law. The lack of communication between the Probation Department and the public assistance agencies may result in replicated support for the same minor. If there is no "Stop Order" issued in a timely manner, or not issued at all, it may take months for funding to be halted and realize that substantial taxpayer funds may be wasted. DPSS, DCFS and Probation need to work together and implement an information sharing process. Probation needs to inform the child support agencies when a minor is in custody for thirty days. A protocol needs to be developed to avoid replicate funding. If payments are not discontinued or unjustified payments are made, attempts should be made to recover such overpayments. The Probation Department's responsibility is to expeditiously complete the financial screening of the family and communicate this information to the appropriate agencies.

HISTORY

The Los Angeles County Probation Department handles over 20,000 custodies annually with a staff of 5,800 and a budget of $630[1] million. The size and transient nature of the custodies underscores the responsibility and diverse services required of the Department while adhering to the myriad federal, state and local laws. Within this oversight they must provide medical care, mental health, education, behavioral rehabilitation and be involved with any other agency

providing care for a minor's custody. Within this area lies a responsibility to report to the supportive agencies (DPSS and DCFS) to prevent replication of costs for those minors adjudicated and sentenced to juvenile hall, camps or probation group homes. California's Welfare and Institutions Codes Sections 900-914 covers the above issues.

With the cost of maintaining a minor in custody spiralling upwards, approaching $200 a day[1], there is a need to address the lack of communication and oversight between supportive services and the Probation Department. Due to the layering of department and service providers, it is difficult to pinpoint who is charged with this reporting and at what point the information should be submitted.

There is no statistical data available for the numbers of minors coming from DCFS funded units, group homes and foster care, or from DPSS comprised of CALWORKS funded units. Along with DPSS funding is the availability of food stamps, medical care, housing assistance and childcare, all of which is based on the number of individuals residing in the unit.

PURPOSE

In accordance with California Welfare and Institution Codes Sections 900-914 when minors are placed in the custody of the Juvenile Probation Department for thirty days or more, any agency providing funding for that minor must be notified so as to terminate funding for that minor. This notification ensures that the taxpayers are not paying twice for the minor's care and support while being held. The investigation attempted to:

- Determine what mechanism is in place to avoid funding of minors in custody when their homes are simultaneously receiving support from various social service agencies.

- Identify the appropriate mechanism to be implemented to stop the replication of funding.

- To determine what agencies are involved and who is responsible for triggering that mechanism.

- Recover any monies that have been inappropriately paid, creating a duplicated taxpayer support of the minor in custody.

- Make sure measures are in place to aggressively seek reimbursement of overpaid funding.

1 Probation Department, Administrative Services, 5/1/07

Methodology

- Visit to Eastlake Juvenile Hall
- Interview with staff from the Office of Supervisor Yaroslavsky
- Round table session with department heads from DPSS, including Fraud, Food Stamps and CALWORKS
- Individual interviews with top officials from Probation and DPSS
- Review of intake paperwork for minors entering Juvenile Probation
- Review of materials provided by DPSS on eligibility, programs and participation requirements
- Review of DPSS "QR7" form for "self reporting" of family unit status for funding and benefits including by not limited to cash aid, Food Stamps, Medi-Cal
- Reading newspaper articles relating to lack of oversight in DPSS and DCFS funding of families
- Review of documents

    1. AB 129, now part of California Welfare and Institutions Code
    2. California Welfare and Institutions Code Sections 900-914, Section 17402 of the Family Code
    3. Department of Justice Investigation of Probation in 2000

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FINDINGS

- The welfare agencies in Los Angeles County are the Department of Public Social Services and the Department of Children and Family Services
- DPSS has over a million clients and over 13,000 employees
- There are no communications between the Juvenile Probation Department and DPSS
- Approximately 30% of the Juvenile Probation caseload stems from a public welfare background. There appears to be no accurate data available.
- DPSS may provide no direct supervision of individuals in their caseloads in the course of a year. They depend upon a "self report" by the family unit.
- This "self report" form is complicated and difficult to understand.
- Probation does a financial screening and bills parents or guardians for reimbursement. The department collects about 2.8 million dollars per year in reimbursements.
- Probation does not charge families who document that they are receiving welfare funds
- Recent state legislation delineates the roles of DCFS and Probation.
- Federal regulations require DCFS monitor families directly.

CONCLUSION

Based on the history of these streams of funding, the transition of minors from social services backgrounds to Probation shows a lack of communication between agencies and a substantial amount of money being wasted through replicated payments for the same minor. If there is no "Stop Order" issued in a timely way, or not issued at all, it may take months for funding to be halted. It is important and necessary for DPSS, DCFS, and Probation to work together and implement an information sharing process that alerts DPSS and DCFS to expeditiously adjust applicable public assistance and/or foster home or group home payments to reflect the absence of the incarcerated minor from the household. There is need to establish a standardized protocol which reflects the household's financial status. If there is DPSS or DCFS involvement, these agencies need to be notified when the minor is adjudicated for thirty or more days to the custody of Probation.

RECOMMENDATIONS

Recommendations for the Probation Department, Department of Public Social Services, Department of Children and Family Services, and Department of Child Support Services:

- Establish a liaison between Probation and DPSS and DCFS. These agencies need to work together to design and implement an information sharing process.

- Notify each agency contributing to the support of a minor when the minor is in custody more than 30 days pursuant to the Welfare and Institutions Codes, Sections 900-914

- Require a protocol to avoid replicate funding. If payments are not discontinued or unjustified payments are made, actively seek recovery of overpaid monies.

- Require the Probation Department to expedite completion of a financial screening.

- Immediately communicate this information of the financial screening to the appropriate agencies.

Crisis in Communication

Preventing Child Fatality and Maltreatment

DCFS-FAST Committee

Linda F. Winfield, Chair
Bob George, CoChair

Emilie Anselmo
Joe Contreras
Hannah Margolis
Otha Scott
Ung Yol Yu

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

F.A.S.T.

Finding a safe tomorrow
for children in LA County

CRISIS IN COMMUNICATION
Preventing Child Fatality and Maltreatment

PURPOSE

To investigate the data collected, shared, and analyzed on child death, neglect, and abuse within Los Angeles County.

Timely and appropriate sharing of information to key personnel will allow earlier intervention in cases of severe or repeated abuse to prevent child fatalities.

PREFACE

CRISIS IN COMMUNICATION
Preventing Child Fatality and Maltreatment

*A social worker receives a call from a distressed parent whose 4 year old child has been abducted. This family is one of the dependents receiving services in Los Angeles County. There is a restraining order against the estranged spouse, however, he is at Los Angeles International Airport about to leave for the Philippines with the child. The call is forwarded to the Emergency Response Supervisor who must now unravel the bureaucratic maze of confidentiality getting information from child welfare records, court document and law enforcement. Because Los Angeles Airport is involved, and a child was being transported out of the country, LAX security, Homeland security, and the FBI were also involved. Some **14 hours later**, after numerous phone calls, multiple faxes, "access denied" and rejections from existing data bases, a skilled Supervisor overcame the difficult barriers and hurdles by using his 30+ years of experience and personal contacts to obtain information required to prevent the abduction.*

The above incident actually occurred in 2006 in Los Angeles County and highlights the need for appropriate individuals to have authorized access to certain information on wards and dependents of Los Angeles County. At the same time, there are federal, state and county restrictions on releasing such confidential information which can work against the safety and well being of dependent children. These issues need to be reviewed and methods designed to allow proper secure access when in the child's best interest. Case records are confidential for DCFS clients and confidentiality is also given to those who report child maltreatment to DCFS along with any subsequent reports generated. Currently, there is no centralized data base of records on child abuse and neglect.

- ☐ *What steps must transpire and what information must be communicated across departments in order to protect dependent children?*
- ☐ *When can court records be obtained, and law enforcement be notified?*
- ☐ *What information, if any, can be obtained from the Child Welfare data base?*
- ☐ *What might occur if a less experienced manager is faced with this set of circumstances?*

In spite of efforts by the child welfare system, child abuse and neglect fatalities remain a serious problem. Although the tragic, untimely deaths of children due to illness and accidents have been closely monitored, deaths that result from abuse and neglect can be more

difficult to track because the perpetrators are less likely to be forthcoming about the circumstances, particularly if they are related to the victim. Intervention strategies targeted at solving this problem face complex challenges.

EXECUTIVE SUMMARY

A profound concern about the number of deaths occurring each year within the County among abused and neglected children (15-53 in the years 2003-2006) led the 2006-2007 Los Angeles County Civil Grand Jury to investigate the protection and care for such children provided by the Department of Children and Family Services (DCFS) and the Department of Health Services (DHS).

A major area of investigation was the lack of sharing of critical information between departments and agencies. Major concerns revealed are: the restrictions placed upon that sharing by legal restraints, the inadequate sharing processes that currently exist, and the apparent lack of urgency in developing technological system solutions that could facilitate this data sharing among authorized professionals.

These problems persist because DCFS and DHS function independently without a higher authority that could require them to better coordinate their operations, their systems, and their information sharing.

The investigation into these matters required an extensive series of efforts. These included:

- ☐ Reviews of the Federal and State laws that related to confidentiality matters
- ☐ Reviews of DCFS and DHS policies, procedures and operations information
- ☐ Collection and review of practices in other jurisdictions regarding confidentiality
- ☐ Extensive interviews with DCFS managers and staff
- ☐ Extensive interviews with DHS managers and staff
- ☐ Interviews with other County agencies and private organizations
- ☐ Reviews of best practices in other counties and states
- ☐ Research of other best practices in other key sources

The investigation focused on five major areas:

1. Federal, state and local law and policy issues

   Some other California counties have had better success in information sharing. Los

Angeles County has recently adopted an interagency Memorandum of Understanding stating that DCFS and DHS will develop protocols to improve data sharing.

2. Information technology issues

   Existing systems within DCFS and DHS do not enable information sharing. Development of new systems that could facilitate this sharing is lagging.

3. Interdepartmental collaboration, information sharing and the HUB clinics

   While such limited approaches as multidisciplinary teams (combining several technical and social workers) and HUB clinics (specializing in services for abused and neglected children) have represented some improvement in care, there is a need for enhanced management oversight of the two departments coordination and information sharing.

4. Public health nurses

   Public Health Nurses represent an improvement in the care of some children, but their effectiveness is limited by the inadequate access to patient records and the fact that their management is divided (half report to the Department of Public Health, half to the Department of Children and Family Services).

5. Prevention and data sharing

   DCFS's prevention efforts are relatively new. The Department implemented a pilot program in 2004 called Point of Engagement. This provides for more community-based services for families experiencing problems but with a low risk of child abuse and neglect.

   To be successful, this effort will require well managed information and data sharing, needs which are not now being met.

The Grand Jury concludes that the threat to abused and neglected children within the County remains a serious concern. It recognizes the efforts of DCFS and DHS to provide care and security for such children, but it has determined that the existing system of information exchange is not adequate, and, indeed puts some children unnecessarily at risk.

The efforts to work through the barriers of information confidentiality and the steps being taken to establish a comprehensive data sharing system is inadequate. Stronger and more urgent efforts are required to insure that vulnerable children are given proper security and care.

Recommendations

1. Federal, state and local law and policy issues

The Department of Children and Family Services should:

1.1 Amend Department policies to include protocols for expediting release of routine medical histories and information to multidisciplinary teams and DHS medical personnel who are providing services to children under the jurisdiction of DCFS.

1.2 Assign responsibility to a DCFS manager for ensuring and documenting that routine medical histories and information are provided timely to multidisciplinary teams and DHS medical personnel in compliance with the recommended new expedited protocol.

1.3 Provide reports on a regular basis such as monthly to DHS hospitals on the outcomes of all child maltreatment reports filed for each hospital and other reporting facilities.

1.4 Research with County Counsel, and follow up with the Juvenile Court as appropriate, the possibility of requesting that the Juvenile Court issue blanket orders authorizing release of DHS medical records to DCFS in instances when the parents or guardians have not provided such records to DCFS.

The Department of Health Services should:

1.5 Assign hospital SCAN Teams responsibility for maintaining centralized lists of all child maltreatment reports filed by staff at their facilities and for analyzing and using child maltreatment report outcome data provided by DCFS to adjust training and protocols related to child maltreatment reporting at their facility.

1.5.1 Data collection be expanded to include outpatient clinics in tracking transfer of children from hospitals to clinics which would provide additional centralized list of all child maltreatment reports

1.6 Research with County Counsel laws, regulations and possible options to enable release of medical records to DCFS other than those related to a current incident as part of Department.

The Board of Supervisors should:

1.7 Consider lobbying the State Legislature for changes in law that would provide DCFS and other child protective services agency with discretion in sharing records and data about children in their system, based on a determination that such sharing is in the best interests of the child and clarifying that DHS can share other medical records relevant to DCFS, even if they are not for the current charge of child maltreatment, as appears to be allowed by Commonwealth of Virginia statutes.

1.8 Request that the CEO assign an assistant to further implement the interagency Memorandum of Understanding that has been adopted by DCFS, DHS, DMH and

Probation regarding data sharing across departments. Move to immediately implement data sharing between DHS (mHUB) and DCFS (my CSW) to promote the safety of foster children and their compliance with medical and mental health treatment plans and follow up care.

2. Information technology issues

The Board of Supervisors should:

2.1 Implement mHUB and myCSW links between 1) all medical HUBS 2) medical HUBS and DCFS. Further assessment of CHEERS may be useful for inclusion of education and emancipation information in the county-wide data base.

2.2 Direct the County Internal Services Department to work with DHS and DCFS to assess which of the alternative short term interface systems would be most able to be integrated with planned upgrades and improvements in DHS and DCFS information system.

2.3 Request that the CEO appoint an assistant to coordinate the implementation of new information technology and data sharing between DHS and DCFS

3. HUB Clinics

The Board of Supervisors should direct the Chief Executive Officer to:

3.1 Appoint an assistant to assume countywide management responsibility for ensuring the effectiveness of Countywide interagency collaboration and data sharing efforts directed toward abused and neglected children, including the medical HUBs and other multidisciplinary teams, including the enhanced support of HUBs to include POE and MAT services.

The Board of Supervisors should direct DCFS to:

3.2 Assign Public Health Nurses to staff the HUB clinics in addition to Children's Social Workers since all children in the DCFS system are already assigned a social worker who could still serve on the multidisciplinary teams for the children in their caseload; and

3.3 Define the multidisciplinary teams at the HUB to serve as "standing" teams responsible for direct services and/or ongoing monitoring of cases and to be comprised of HUB physicians, Public Health Nurses and mental health providers with rotating members for each case consisting of the child's biologic parents and/or caregivers, Children's Social Worker, foster care providers, congregate-care providers and others.

The Board of Supervisors should direct DHS to:

3.4 Conduct a thorough evaluation of the workload and capacity of existing HUBs with a focus on potential efficiencies that may be gained in the existing system and ways to increase capacity, including their geographic and population coverages and how well the existing structure serves the County both in terms of area and population; and

3.5 Collaborate with DCFS, Department of Mental Health and other key stakeholders to expand the existing system as necessary to ensure that eventually all or most children in the DCFS system can be served by the HUBs. All children should initially be assessed by HUBs and DCFS and DHS should provide additional staff to adequately case management services at each HUB.

The Board of Supervisors should direct DCFS and DHS to:

3.6 Develop policies and procedures that give priority for HUB clinic services to children at high risk or with higher medical needs such as Medically Fragile cases in the form of direct services when this is the best medical option available or in the form of case management if the children need specialist care outside of the HUB structure. Enhance existing HUB services to provide expanded access to appropriate care for all medically fragile cases through either direct service or case management and referrals to community providers.

3.7 Assist ICAN in its integration efforts by incorporating it into DCFS so that it can continue to maintain its ongoing review of child deaths.

3.8 Create an interagency pilot program as an extension of the hospital SCAN teams (or some interim system) to assist in investigating suspected child abuse and neglect for all the dependents in DCFS.

4. Public Health Nurses

The Board of Supervisors should direct the Chief Executive Officer to appoint an assistant to oversee the Departments in order to:

4.1 Amend the Memorandum of Understanding between DCFS and the Department of Public Health, if necessary, to allow for dotted line reporting relationships so that Public Health Nurse supervisors to report to DCFS District Office/SPA Regional Administrators, including allowing those Administrators to provide input to the PHN performance evaluations;

4.2 With input from DCFS line staff and managers, establish and begin collecting data for monthly reports to the Regional Administrators using a consistent set of activity and outcome measures for which all PHNs can be held accountable, including measures of their effectiveness in obtaining healthcare documentation from DHS and other medical care providers, assessing healthcare services provided, assessing and verifying medical

information prior to entering it into CWS/CMS, and facilitating the sharing of medical information with healthcare providers;

4.3 Assign a single DCFS manager responsibility for ensuring and documenting that the key case management function of entering medical records into CWS/CMS for all cases by either Public Health Nurses or other appropriate staff so that the records are available when needed for children's medical appointments.

The Board of Supervisors should direct DCFS and the Department of Public Health to:

4.4 Consider an alternative system of medical record data entry, such as using Intermediate Typists Clerks or a similar County classification for the majority of routine cases so that Public Health Nurses are utilized in a more efficient and effective manner but would still be available for assisting with interpretations of the more complex medical information and records obtained by DCFS for entry in to CWS/CMS.

The Board of Supervisors should direct the Department of Public Health to:

4.5 Apply for a waiver from the state Health Care Program for Children in Foster Care program definition of foster child, enabling its PHNs to serve any child who is referred to, or is part of, an open case at DCFS;

4.6 Collaborate with DCFS to amend their Memorandum of Understanding to enable all Public Health Nurses to serve any child in the DCFS system who is referred to, or is part of an open case at DCFS;

4.7 Evaluate the situation in other counties to see if Public Health Nurses are restricted from serving certain children in the DCFS system and, depending on the findings, amend its definition of foster child to enable PHNs to serve any child welfare referral or open case.

5. Prevention and Data Sharing

The Board of Supervisors should direct the Chief Executive Officer to appoint an assistant to oversee the Departments in order to:

5.1 Conduct the quantitative evaluation recommended in the Children and Families Research Consortium report and include the Department's other prevention activities such as the activities of the Community-Based Support Division;

5.2 Evaluate POE as part of the integrated HUB service. This will guarantee inclusion of the medical and forensic assessments and extend the connections of mHUB with my CSW to enable monitoring of intervention/prevention strategies.

5.3 Use DCFS data base linked with mHUB (or DHS data base) to monitor safety of children identified as "at risk" (i.e., children identified early or brought to HUBs but not detained)

to determine effective strategies to prevent children from abuse and mandated intervention by DCFS.

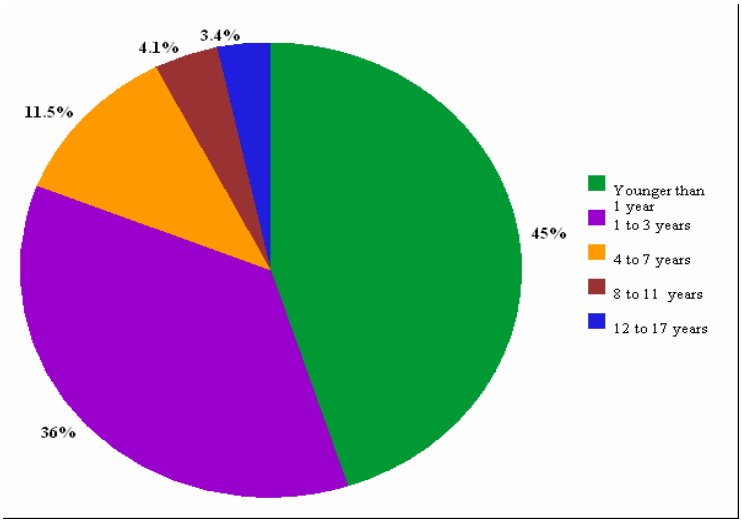
5.4 Involve the Department's Public Health Nurses in Point of Engagement Team Decision Making process and other planned prevention activities to ensure a source for information and data sharing with the Department of Health Services HUB clinics and other healthcare facilities regarding families served through the prevention activities; and

5.5 Designate specific SPA/District Offices to be served by specific Community-Based Support Division staff to ensure that prevention services are provided Department-wide and that performance results can be tracked by each Department office.

History

National statistics indicated that an estimated 1,440 child fatalities occurred in 2004. Child fatality is defined as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor[19]. This number translated into a rate of 2.03 children per 100,000 children in the general populations. Tragically, these deaths tend to occur among younger children[20]. 81% of these deaths occur with children age 3 or under. See Exhibit 1.

Exhibit 1
Child Abuse and Neglect Fatalities Victims by Age 2004
Child Welfare Information Gateway, 2006



There has been public concern that children in foster care are at a higher risk of death as compared to the population at large, and that there may be an increased incidence of homicide resulting from inappropriate placement with abusive caregivers[21]. Nationally, in 2004, one or both parents were involved in 78.9% of child abuse or neglect fatalities. Of the other 21.1 percent of fatalities, 10.7% were the result of maltreatment by non parent caretakers, and 10.4

[19] Child Welfare Information Gateway, 2006, "Child Abuse and Neglect Fatalities: Statistics and Interventions", http://www.childwelfare.gov/pubs/factsheeets/fatality.cfm. Washington, D.C.: U. S. Department of Health & Human Services, Administration for Children & Families.

[20] Child Welfare Information Gateway, 2006, Richard J. Fantus and John Fildes, "Peds 2: Twice as large", Bulletin of the American College of Surgeons, October; 43. William Scarborough and Amy Paulin 2006, "Children Don't Just Die, Report on Child Fatality Review in New York State", New York State Assembly Standing Committee on Children and Families.

[21] Sharon Bernstein, 2006. "Killings of youths tied to Los Angeles County child protection system soar in 2006." Los Angeles Times, December 23, 2006, www.latimes.com/new/local.

percent represent unknown or missing information[22]. Intervention strategies targeted at solving this serious issue face complex challenges[23].

Los Angeles Experience

Due to concerns and the need for accurate and appropriate information, the Civil Grand Jury (CGJ) conducted a preliminary investigation on data collection and sharing across DCFS and DHS. This data is necessary to safeguard the well being of vulnerable children at-risk of maltreatment. A list of interviews and meetings can be found in Appendix A.

From our preliminary investigation, the CGJ found that the Inter Agency Council on Child Abuse and Neglect (ICAN) was created by DCFS in 1977 to find and investigate each and every child death with Los Angeles County. The complexity and volume of dependents in the county system resulted in varying data collected on this topic by multiple departments with no linkage. For example, among the many data systems CGJ identified include: The Family Child index (FCI) created by ICAN for agencies to input information on child abuse, E-SCARS (Suspected Child Abuse and Reporting) an electronic system for reporting suspected child abuse established by the District Attorney's Office, Sheriff and DCFS, SCAN which is at the hospitals, and multiple other systems. The ICAN reports, although informative are not analyzed and acted upon by the Departments, and other efforts at systems and data integration and sharing occur without their input; e.g., HUB's created for the medical assessment of dependent children newly detained.

Historically, trauma has been a major health dilemma in Los Angeles County. In 1996, the overall homicide rate per 100,000 population was 14.0 and in the age group 15 to 34 years, the rate was 164.2 per 100,000[24] . Prior research, during this time period found a relationship between children in protective services and incidence of homicides in Los Angeles. Children who died of homicide were 3.14 times as likely as those whose deaths were unintentional to have suffered prior abuse and contact with child protective services prior to their deaths[25].

In 2006, there were 121 recorded child deaths which occurred under the supervision of DCFS. There were twice as many deaths due to homicide (53) as compared to those children dying from medical or natural causes (23). Other modes of death included: accidents, suicide and undetermined. This information is shown in Exhibit 2.

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[22] Child Welfare Information Gateway, 2006.

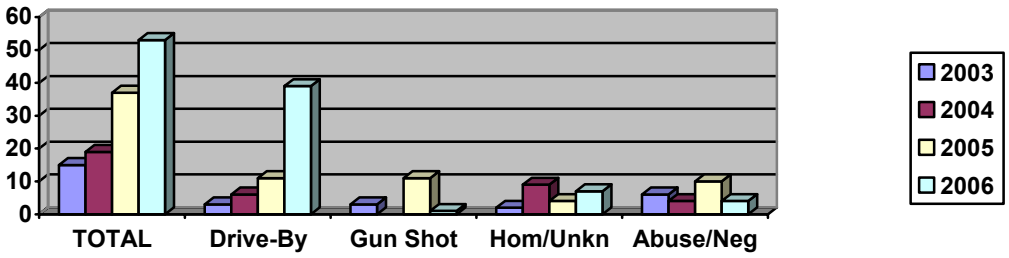
[23] Child Welfare Information Gateway, 2006. Stuart Slavin, 2004, "Domestic Violence: Impact on Children and Implications for Screening", Paper presented at Delivering Word Class Medical Education: Current Clinical Issues in Primary Care, Long Beach Convention Center, Long Beach, CA. April 3-5. Annie Lewis-O'Connor 2004, "Domestic Violence: An epidemic in our homes." Paper presented at Delivering Word Class Medical Education: Current Clinical Issues in Primary Care, Long Beach Convention Center, Long Beach, CA. April 3-5.

[24] D. Demetriades, J. Murray, B. Sinz, D. Myles, L. Chan, L. Sathyaragiswaran, T. Noguichi, F. S. Bongard, G. H. Cryer, D. J. Gaspard, 1998, "Epidemiology of major trauma and trauma deaths in Los Angeles County", Journal of American College of Surgeons, October, 187 (4), 373-83.

[25] Susan B. Sorenson and Julie G. Peterson (1994), "Traumatic child death and documented maltreatment history, Los Angeles", American Journal Public Health, 84 (4) 623-627.

Exhibit 2

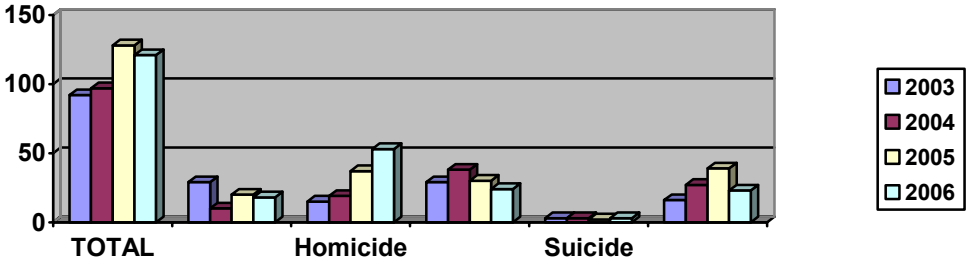
Los Angeles County Department of Children and Family Services
Yearly Comparison of Homicides by Type 2003-2006



A breakdown of homicides that occurred indicated that 39 were due to drive-by shootings, and another 7 were by an unknown person. This information is shown in Exhibit 3. The sharp increase in homicides in 2006 were children in custody; however the deaths occurred in their home neighborhoods.

Exhibit 3

Los Angeles County Department of Children and Family Services
Child Fatalities by Mode of Death 2003-2006



The number of homicides by case status within DCFS indicated that a total of 4 children who were victims of homicide also had a prior or open case[26]. This information is shown in Exhibit 4.

[26] All DCFS data provided by Department of Children & Family Services, October 2006.

Exhibit 4
Los Angeles County Department of Children and Family Services
Homicides by Abuse and Neglect with Case Status 2003-2006

DCFS Status	2003	2004	2005	2006	TOTAL
Abuse/Neglect Homicides					
Open Cases	4	2	5	2	13
Open Referrals	2	0	0	0	2
Prior Case	0	0	1	1	2
Prior Referrals	0	2	4	1	7
Total	6	4	10	4	24

There were 33 child homicides by parent/caregiver/family member in 2005[27]. An examination over the last fourteen years indicated that on the average, 15 homicides occurred with families who had previous contact with DCFS. The distribution of child homicides from 1990 to 2004 by parents/caregivers/family members is shown in Exhibit 5.

Exhibit 5
ICAN Child Homicides by Parents/Caregivers/Family Members[28]

Year	Total # of homicides by parent/care giver/family member	Total # of homicides that had previous DCFS Contact (prior contact OR open case)	Of total with previous DCFS contact, the # of homicides that had PRIOR DCFS contact only	Of total with previous DCFS contact, the # of homicides in OPEN DCFS case or referral	# killed by out-of- home caregiver
1990	46	11	5	6	0-foster parents unable to determine relative caregivers
1991	61	11	5	6	1-foster parent unable to determined relative caregivers
1992	46	11	5	6	0-foster parents unable to determine relative caregivers
1993	41	13	6	7	0-foster parents Unable to determine relative caregivers
1994	39	12	5	7	0-relative caregivers 1-foster parent
1995	49	16	5	11	3-relative caregivers 0-foster parent

[27] Inter-Agency Council on Abuse and Neglect (ICAN) 2006. The State of Child Abuse in Los Angeles County, 34.

[28] Data supplied by Inter Agency Council on Child Abuse & Neglect (ICAN), October 2006. * ICAN currently organizing these data.

Year	Total # of homicides by parent/care giver/family member	Total # of homicides that had previous DCFS Contact (prior contact OR open case)	Of total with previous DCFS contact, the # of homicides that had PRIOR DCFS contact only	Of total with previous DCFS contact, the # of homicides in OPEN DCFS case or referral	# killed by out-of- home caregiver
1996	53	13	7	6	2-relative caregivers 2-foster parents
1997	45	15	8	7	0-relative caregivers 1-fosterparents
1998	49	20	16	4	0-relative caregivers 0-foster parents
1999	44	20	12	8	1-relative caregiver 2-foster parents
2000	35	15	7	8	2-relative caregivers 0-foster parents
2001	35	12	7	5	3-relative caregivers 2-foster parents
2002	37	*	*	*	0-relative caregivers 0-foster parents
2003	35	18	13	5	2-relative caregivers 2-foster parents
2004	30	15	9	6	2-relative caregivers 0-foster parents

CGJ concluded that although the total annual number of child deaths is small and within the State and national children's death rate, **each loss is a tragedy and should be assessed as to how the loss of life could have been prevented**[29].

- ☐ What procedures are in place to prevent such tragedies?
- ☐ What procedures are in place to review and identify problematic trends that when modified and put into action might save a life?

The strategies and procedures most critical to answering the above questions lie in the early detection, prevention, and appropriate intervention of repeated abuse situations or near fatal abuse situations. The volume and number of referrals that are handled yearly by DCFS present a daunting challenge since many of these children as dependents of the County are vulnerable and at high risk for abuse. In 2005, DCFS received an average of 13,069 referrals per month. Of these, roughly 90% required an in-person investigation[30]. There were 156,831 referrals for various forms of abuse in 2005. These numbers by allegation type for calendar year 2005 are shown in Exhibit 6[31].

[29] Forum on Child and Family Statistics, 2005, "America's Children: Key National Indicators of Well-Being ", Child Stats.gov. http://www.childstats.gov/amchildren06/hea7.asp/, National Center for Child Death Review (2003) U. S. Department of Health and Human Services, http://www.childdeathreview.org/statistics.CA.htm.

[30] Inter-Agency Council on Abuse and Neglect (ICAN) 2006, The State of Child Abuse in Los Angeles County, 132.

[31] Inter-Agency Council on Abuse and Neglect (ICAN) 2006, 148.

Exhibit 6

Los Angeles County Department of Children and Family Services
Referral Children Received By Allegation Type Calendar Year 2005

Allegation Type	Children	Percentage
Sexual Abuse	10,647	6.8
Physical Abuse	31,180	19.9
Severe Neglect	1,715	1.1
General Neglect	43,264	27.6
Emotional Abuse	12,719	8.1
Exploitation	193	0.1
Caretaker Absence/Incapacity	7,201	4.6
At Risk, Sibling Abuse	30,647	19.5
Substantial Risk	19,265	12.3
TOTAL	156,831	100.0

There have been prior attempts to redesign the state child welfare system from a crisis-orientation to a more proactive system responsive and sensitive to the needs of children at risk[32]. Similarly, under the leadership of the former director, Dr. David Sanders certain changes were implemented to create a more transparent organization and reform outdated policies and procedures to care for children and families in vulnerable conditions. One of the many reforms initiated in 2002 was a county-wide task force to create a comprehensive prevention plan. However, this plan was never funded[33] .

The DCFS response to the 2001-2002 Civil Grand Jury Audit regarding the assessment of the quality of child abuse investigations provided specific procedures. This process is critical in assessing performance in any system[34]. These six steps are summarized in Exhibit 7.

Exhibit 7

Process Described in DCFS Response to
2001-2002 Grand Jury Audit

1) **Accurate data collection**
2) **Analyze current data**

[32] California Child Welfare Services (CWS) Redesign. Bold Changes: A Shared Responsibility for Children & Families. Pilots to Policy Conference, February 4, 5, 2004. Hilton, Glendale, California. The Foundation Consortium for California's Children & Youth.
[33] Preventing Child Maltreatment: A Comprehensive Plan for a Continuum of Family-Centered Community-Based Prevention and Intervention Services for Children, Youth and Families in Los Angeles County. Prevention Workgroup, n.d.
[34] Marjorie Kelly, Interim Director, DCFS, "DCFS Response to County Board of Supervisors, Synopsis #69 Supervisor Knabe's 2002 Motion: Grand Jury", August 21, 2002, 10.

3) **Write data analysis report**
4) **Create action plan to modify problematic trends**
5) **Implement action plan**
6) **Evaluate after six months to assess effectiveness**

These criteria should be used when assessing any data being collected on dependents in DCFS.

Because of the serious nature of the allegations in the news media, and our preliminary investigation, the CGJ felt the need to conduct a professional audit to understand the progress, and barriers in collecting and sharing accurate data. Because of time constraints, three departments were selected for inclusion: DCFS, DHS, and ICAN. This audit would identify departmental policies, procedures and information sharing to help prevent future tragedies. Appropriate data collection and analysis would enable the discovery of problematic trends and the creation of a plan of remedial action to address these critical and urgent issues. Standardized and eventually, automated protocols would improve the quality of data collected and be a means of standardizing training for all health care providers. **Improved data, analysis and information sharing will allow earlier intervention in cases of severe abuse to prevent death.**

Introduction

This audit report on Data Collection, Reporting, and Sharing at the Los Angeles County Department of Children and Family Services and the Department of Health Services to Prevent Child Abuse, Neglect and Death was conducted for the Fiscal Year 2006-07 Civil Grand Jury of Los Angeles County.

The audit sought to answer the following questions:

1. What are the current Department of Children and Family Services (DCFS) and Department of Health Services (DHS) procedures and information systems used to collect and analyze data on child abuse, neglect and death?
2. What is the active role of Inter agency Council on Child Abuse and Neglect (ICAN) in the coordination and development of services for the prevention, identification, and treatment of child abuse and neglect?
3. How is child death reporting coordinated and analyzed throughout the County?
4. What other information is collected by federal, state or other local agencies that is, or could be used by DCFS and DHS to assist them in identifying, analyzing and preventing cases of child maltreatment?
5. To what extent is the collected data shared between DCFS, DHS and other County and local agencies involved in child maltreatment services?
6. To what extent are current data collection efforts and sharing of information enabling prevention of child maltreatment?
7. What federal, state, local laws and policies are inhibiting information sharing between DCFS, DHS and key service providers in the County?
8. What technical issues such as incompatible information systems are inhibiting data sharing between the DCFS, DHS and key service providers in the County?
9. What other issues, such as management policies, are inhibiting information sharing between DCFS, DHS and key service providers in the County?

The issue of data sharing and interagency coordination on child abuse, neglect and death necessarily involves many organizations throughout the County of Los Angeles. In general, all health and social service providers in all departments should be a source of data collection. Due to time constraints, the Civil Grand Jury (CGJ) focused their investigation on DCFS, DHS, and (ICAN). Thus, this audit focused primarily on these departments.

Methodology

Several complementary audit methods were used to understand and analyze the issues related to data sharing and interagency coordination between DCFS and DHS, including:

- Collection, review and analysis of federal and state laws related to confidentiality information and record sharing by child welfare and health agencies.

- Collection, review and analysis of DCFS and DHS policies, procedures and operations information, including documents covering the following topics:

    - Mandated Reporters of child abuse, neglect or death
    - Sharing of information from DCFS to other agencies
    - Sharing of information from DHS to other agencies
    - Multidisciplinary Teams and their current utilization
    - Public Health Nurses Program, its background and utilization
    - DHS HUBs, their locations, staffing, current utilization, data gathering and sharing activities
    - DCFS and DHS information technology and systems, including DCFS Advanced Planning documents, and related federal communications
    - DCFS Hotline and Line staff procedures and statistics

- Interviews with the following DCFS managers and staff

    - Chief Deputy Director
    - Medical Director
    - Assistant to Deputy Director of Information Systems
    - Two Deputy Directors
    - Two Regional Administrators
    - An Assistant Regional Administrator
    - Two Nurse Managers
    - A group of Children's Social Workers (CSWs)
    - A group CSW Supervisors
    - Two DCFS Public Health Nurses (PHNs)
    - Three DHS PHNs and a PHN Supervisor

- Interviewed the following DHS managers and staff

    - Deputy for Planning and Program Oversight
    - Chief Information Officer
    - Chief Executive Officer, Harbor/UCLA Medical Center
    - Key executive managers, Harbor/UCLA Medical Center
    - Executive Director, Violence Intervention Program (VIP), USC
    - Managers from VIP and a representative from Saga Systems
    - Managers from Harbor/UCLA HUB clinics
    - Staff from Harbor/UCLA HUB

- Interviews with representatives from the following other County agencies and private organizations:

    - County Counsel
    - Interagency Council on Child Abuse and Neglect

- Children's Law Center, Los Angeles
- The Alliance for Children's Rights
- Los Angeles County Education Coordinating Council
-

Collection, review and analysis of documentation on the practices of other jurisdictions relative to data sharing and interagency coordination to prevent child abuse, neglect and death

- Reviewed best practices in the following jurisdictions:

  - The State of Florida
  - Commonwealth of Virginia
  - Alameda County, CA
  - San Diego County, CA
  - Placer County, CA

- Researched other resources for best practices, including the following key sources:

  - The National Children's Alliance
  - Virginia Department of Criminal Justice Services
  - Office of Juvenile Justice Programs
  - California Attorney General's Office
  - Sage Publications

The remainder of this report contains the audit findings, conclusions and recommendations.

Findings and Recommendations

1. Federal, state and local law and policy issues

- Federal and state laws governing the privacy of medical and child abuse records presents some obstacles to information sharing between the Department of Children and Family Services (DCFS) and Department of Health Services (DHS). However, state law does allow health and child welfare agencies to share otherwise confidential records under the auspices of interagency multidisciplinary teams. A number of such teams are in place in Los Angeles County, including some with representatives of DCFS and DHS. While creation of such teams represents the potential for improved service levels for children in the child welfare system, the teams' efforts have been mixed due to a variety of technological and management issues.
- Some other California counties report that they have had success in interagency information sharing, improved coordination of services through creation of standing, or ongoing, multidisciplinary teams and use of information systems that enable data sharing. Other states have laws in place that are more explicit about the overriding need for child welfare workers and medical providers to share information about mutual clients.
- Los Angeles County has recently adopted an interagency Memorandum of Understanding that establishes an Operative Principle that those who have custody of a minor should have all the health and mental health information they reasonably need to promote the health and safety of these minors, to prevent duplicate health and mental health services and to promote continuity of care. The Memorandum of Understanding states that DCFS, DHS, Department of Mental Health (DMH), Probation and other County departments will be developing protocols to better enable all County departments to share appropriate information for children and families served.

The County Department of Health Services and Department of Children and Family Services both maintain records about their patients or clients that are protected by federal and state confidentiality laws. As a result, attempts to share information about mutual clients between the two departments have been restricted. Under most circumstances, DHS medical providers cannot access information from DCFS to determine if patients who they suspect may be child maltreatment[35] victims have been reported to DCFS in the past or have been proven to be victims of child maltreatment by DCFS in the past. DCFS, on the other hand, cannot access past medical records from DHS or other providers in most instances for children who have been detained or who are being investigated as potential victims of child maltreatment unless the child, their parents or guardians have previously given their consent for the release of such records.

[35] The term child maltreatment is defined to include both child abuse and neglect.

While intended to protect privacy, these restrictions often work against the best interests of children served by the two departments. Without medical records of children in their custody, DCFS' Children's Social Workers are missing a key component of those children's records and less able to ensure that the children are receiving proper and appropriate medical care. Without access to DCFS records, medical providers may be at a disadvantage in making determinations of whether or not a patient's injuries or illnesses are the result of child maltreatment. Summary outcome reports provided to medical providers and their facilities on their reported cases of suspected child maltreatment would be useful to help the providers refine their child maltreatment detection abilities and protocols. Sharing information in cases of a near fatality of a child served by both departments would be helpful to assess and improve both departments' protocols in the interest of avoiding, or minimizing, the reoccurrence of such incidents.

Child abuse record confidentiality laws and policies

Key federal laws regarding confidentiality of child maltreatment records are contained in the federal Child Abuse Prevention and Treatment and Adoption Act (CAPTA)[36]. These laws, amended several times since originally enacted in 1974, provide for federal funding to states in support of prevention, assessment, investigation, prosecution and treatment activities related to child abuse and provides grants for demonstration projects and programs. To receive grants from this program, states must have plans in place that includes, "methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians"[37]. However, CAPTA also includes a provision that allows states to authorize release of these records to:

- individuals who are the subject of the report;
- Federal, State, or local government entities, or any agent of such entities, as described in clause (ix);
- child abuse citizen review panels;
- child fatality review panels;
- a grand jury or court, upon a finding that information in the record is necessary for the determination of an issue before the court or grand jury; and
- other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose.[38]

These allowances provide for exceptions to the confidentiality requirements and support the idea of information sharing between departments such as DCFS and DHS. The last allowance listed above, for "other entities or classes of individuals statutorily authorized by the State", requires a review of what is authorized by the State.

California law restricts inspection of child welfare system case records though it allows a number of exceptions to this rule[39]. Among the exceptions are various court officials, school district

[36] 42 U.S.C. Chapter 67
[37] 42 U.S.C. Chapter 67 §5106a(b)(2)(A)(viii)
[38] 42 U.S.C. Chapter 67 §5106a(b)(2)(A)(viii)(I-VI)

officials, and, "members of children's multidisciplinary teams, persons, or agencies providing treatment of supervision of the minor"[40]. Multidisciplinary teams are defined elsewhere in state law to be,

> "…any team of three or more persons who are trained in the prevention, identification and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. The team may include but not be limited to:
>
> (1) Psychiatrists, psychologists, marriage and family therapists, or other trained counseling personnel;
> (2) Police officers or other law enforcement agents;
> (3) Medical personnel with sufficient training to provide health services;
> (4) Social workers with experience or training in child abuse prevention; and
> (5) Any public or private school teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee."[41]

Los Angeles County Department of Children and Family Services (DCFS) policy states that, "All DCFS staff members, including support staff, are charged with the responsibility of maintaining the confidentiality of case records. Failure to adequately protect the confidentiality of the records in the control of DCFS could result in legal action being taken against the individual responsible for the breach…"[42]. The policy allows for the same exceptions to the confidentiality requirement as provided in state law. It does require that all requests to inspect or have copies of case records directed to an out-stationed representative of County Counsel's Office. A separate but related DCFS policy specifically addresses release of case records to service providers, including doctors. It states that they are, "entitled to access all case records/information necessary to assist…in the development and implementation of the child's and family's service plan and to improve their ability to provide our children with competent and comprehensive care…"[43].

This policy specifically identifies procedures for DCFS workers to follow when a request is made by a medical doctor, including discussion of the request with a Supervising Children's Social Worker, obtaining a signed DCFS request form[44], entering the request in the child's Health Notebook, discussing and obtaining signed approval of the Supervising Children's Social Worker, photocopying the records, blacking out any unauthorized information and, finally, sending a copy to the requestor.

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[5] California Welfare & Institutions Code §827 and 830
[40] California Welfare & Institutions Code §827(a)(1)(J)
[41] California Welfare & Institutions Code §18951(d)(1-5)
[42] DCFS Procedural Guide 0500-501.10
[43] DCFS Procedural Guide 0500-501.20
[44] The form is known as DCFS 4389.

Confidentiality laws and policies regarding reports of suspected child maltreatment

In addition to laws and policies governing DCFS case records, laws are in place that protects the confidentiality of those who report suspected child maltreatment to the Department as well as the subsequent Department reports generated. These laws and polices cover all reports made to the Department of suspected child abuse, whether the concern turns out to be substantiated or not.

Suspected child maltreatment reports to DCFS can be made by any member of the community but are required to be made by "mandated reporters", or certain professions specified in state law who are required to report cases of suspected child abuse or neglect. The professions identified in law include teachers, other school personnel, recreation program staff, child care providers, social workers, probation officers, peace officers, firefighters, physicians, residents, interns, nurses, dentists and other licensed medical personnel, emergency medical technicians, mental health workers, clergy members and others who would have occasion to have contact with and observe children and families where child maltreatment may be occurring.

State law allows the release of reports of suspected child maltreatment and resultant investigations that result in substantiated or inconclusive conclusions to a number of specified entities[45]. Of relevance to this audit, the records can be released to multidisciplinary teams and hospital SCAN teams[46]. Other entities to whom these records can be released include: agencies investigating mandated reports; attorneys representing the child; the District Attorney; County Counsel; the California Department of Social Services; the Presiding Judge of the Juvenile Court; the state Department of Justice; coroners and medical examiners; and others.
DCFS policy is consistent with these provisions of state law[47]. The process for releasing the documents is spelled out in another DCFS policy that states that all requests for release of the reports have to be reviewed by County Counsel out-stationed at DCFS[48]. The same policy details specific steps to be followed if the request is from law enforcement, family court, prosecuting attorneys, out-of-County agencies, family members (or their attorneys), the California Department of Social Service, including its Community Care Licensing division, and the County's Risk Management division. The policy does not specifically address any additional or unique protocols and procedures for providing records to multidisciplinary teams or hospital SCAN teams. The policy is based on the assumption that child maltreatment reporting records will be provided to statutorily allowed entities only upon request. There is no policy indicating that DCFS will routinely provide records regarding child maltreatment reports to DHS or any other government agency unless requested to do so.

[45] California Penal Code §11167.5
[46] Hospital SCAN Teams are interdepartmental teams engaged in the identification of child abuse or neglect at their facility. They are generally comprised of one or more of the following: health care professionals, social workers, representatives of law enforcements and representatives of child protective services. Sometimes their composition is hospital-based; in other instances they may include members from outside the hospital staff.
[47] DCFS Procedural Guide 0500-302-10
[48] DCFS Procedural Guide 0500-501.10

The County Department of Health Services has established policies and procedures governing reporting suspected child maltreatment for their entire department. The Department hospitals have their own policies and procedures in this area[49]. For the most part, these policies concentrate on and mirror State requirements for reporting cases of suspected child maltreatment. They provide legal descriptions of child maltreatment, name the professions that are classified as mandated reporters and provide information and forms for reporting suspected cases to DCFS. Mandated reporter employees are required to sign statements indicating that they understand their legal responsibilities and training is provided to employees on the topic.

The Harbor/UCLA and LAC+USC policies also identify SCAN Teams (Suspected Child Abuse and Neglect Teams) that are part of their child maltreatment assessment and reporting structure. In both cases, the SCAN Teams are multidisciplinary staff teams with expertise in identifying and assessing child maltreatment that assist other medical care providers in assessing whether patients are potential victims of child maltreatment. The Harbor/UCLA policies call for medical care providers to contact the SCAN Team and/or Social Work Department for assistance with patients where child maltreatment is suspected.

None of the DHS policies reviewed make reference to how the SCAN Teams or other multidisciplinary teams can obtain outcome information on reported cases as allowed by state law, and described above. However, the LAC+USC policies and procedures documents[50] includes a description of SCAN teams and describes the importance of their involvement in consulting on development of a treatment plan for follow up with the families of the victims, providing training and education for the rest of the staff at the facility and following up on case dispositions. The document recommends that the SCAN Team maintain a centralized record of all reported child maltreatment cases and collect and use case disposition information from the child protection system to know whether their recommendations were acted upon and to ensure that all procedures are followed and reports are completed. As stated in the procedures document, "Without follow up, the (SCAN) Team is ineffective and risks being perceived as unrealistic and impractical by child protection and other community agencies." Without summary information, the SCAN Teams and DHS hospital and clinic managers do not have benchmarks to assess whether or not their facilities are potentially over- or under-reporting.

The review of practices at Harbor/UCLA conducted for this audit indicate that the SCAN Team is not maintaining a centralized database of all reports filed by the hospital or receiving case disposition information from DCFS or playing the roles described in the LAC+USC procedures document. In fact, the hospital's procedures document states that the Social Work Department should maintain centralized records of all child maltreatment reports filed by hospital staff but this is not occurring either. The practices of maintaining a centralized data base of child maltreatment reports and reviewing and analyzing case disposition information, as allowed by state law and identified as a good practice in the LAC+USC procedures document, would enable

[49] DHS child maltreatment reporting policies provided and reviewed for this audit were for the Department as a whole, Olive View/UCLA Medical Center, Martin Luther King, Jr./Drew Medical Center, Harbor/UCLA Medical Center and LAC+USC Medical Center.

[50] Most of these policies and procedures were prepared by the LAC+USC Violence Intervention Program and cover procedures and protocols for the Center for the Vulnerable Child, a specialized clinic at LAC+USC for children under the jurisdictions of DCFS, and for LAC+USC Medical Center.

Harbor/UCLA Hospital and other DHS facilities to enhance the effectiveness of the hospital's child maltreatment reporting practices.

Medical records confidentiality laws and policies

Federal and state law, namely the federal Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act, both place restrictions on the disclosure of medical records without authorization by the patient. When the patient is a child under 18 years of age, the laws generally require that authorization must be obtained from a parent or guardian if the parent or guardian consented for the subject medical care. In instances when the child consented for the medical care or could have consented for the care under law[51], it is the child who must provide authorization to disclose those records.

Children and their parents and guardians generally have the right under federal and state law to inspect the child's medical records, provided the inspecting party authorized the medical services in the first place. Other exceptions to restrictions on inspecting medical records are provided in state law for other medical care providers, insurance companies and entities that pay for medical services and public health authorities for information on certain diseases. In instances of suspected child abuse, child protective services agencies such as DCFS in Los Angeles County are also allowed to inspect medical records. Case law has established that mandated child maltreatment reporting requirements prevail over the state Confidentiality of Medical Information Act restrictions[52]. However, this exception applies to medical information relevant to the suspected child maltreatment only, complete medical files are not required to be provided to the child protective service agencies.

While federal and state law allow for disclosure of medical records in conjunction with filing a report of suspected child maltreatment, it is less clear how DCFS can access other medical records of children in their custody if they haven't been provided by the child's parents or caregivers. At initial dependency hearings, court protocol is for the child's family to complete a health and education questionnaire[53] which, if completed, would provide DCFS as an agent of the court a medical history of the child. In fact, state regulations require that every dependent child's case file include the names of the child's medical providers, a record of the child's immunizations, known medical problems, medications and a plan that will ensure that the child will receive medical and dental care with attention placed on preventive care[54]. However, DCFS staff and others involved in the system report that completion of these forms often does not occur at the court proceedings and Children's Social Workers are often left without needed medical information for the children they are supervising. This problem is exacerbated in instances when a child is removed from their home and placed with another caregiver who does not have their

[51] Minors are allowed to consent for various types of medical care at various ages, depending on the nature of the care. Examples including mental health services, abortion, drug and alcohol-related care, HIV/AIDS services, pregnancy and others.
[52] People ex rel. Eicheberger v. Stockton Pregnancy Control Medical Clinic, Inc. 249 Cal. Rptr. 762, 768 (3rd Distr. Ct App. 1988)
[53] Judicial Council of California Form JV-225
[54] California Department of Social Services Child Welfare Services Manual Regulations 31-206

medical records or know the child's medical history though they have become responsible through court order for their routine medical care[55].

Multidisciplinary teams allowed by state law again appear to provide an opportunity to address some of the restrictions of federal and state law that, in some cases, may work against the best interests of children in protective services or who are suspected of being victims of child maltreatment. State law allows that:

> "…members of a multidisciplinary personnel team engaged in the prevention, identification and treatment of child abuse may disclose and exchange information and writings to and with one another relating to any incidents of child abuse that may also be a part of a juvenile court record or otherwise designated as confidential under state law if the member of the team having that information or writing reasonably believes it is generally relevant to the prevention, identification or treatment of child abuse."[56]

Past medical records would appear to qualify for disclosure to a child protective services agency under these circumstances, particularly if consent to release them is also obtained.

A final means of overcoming medical record confidentiality restrictions is through court orders. The Juvenile Court can order disclosure of medical records to certain agencies for children in their custody. This can be done on an individual case basis or as a blanket order to certain classes of dependent children. Court orders could be made for certain types of information to be provided to certain County personnel. In addition, the court process provides an opportunity for requesting dependent children and/or their parents or guardians to consent to disclosure of certain types of their medical records to DCFS. Of course, this would not address children who are being investigated by DCFS as potential victims of child maltreatment but have not yet been detained.

An impact of confidentiality restrictions on DCFS is in situations where the Department is investigating a case of suspected child maltreatment and would benefit from obtaining past medical records for the potential victim. Though it may help an investigation, it does not appear that County or other medical providers are obligated or allowed to release medical records in such a situation unless the minor or the minor's parents or guardians provide consent to release the records. This issue was addressed in San Diego County through issuance of a court order permitting the disclosure of otherwise protected medical record information about children needing assessment prior to their detention[57].

[55] Major medical decisions for minors in the care of DCFS are subject to court review and approval.
[56] Welfare & Institutions Code §830
[57] See *A Report on the Feasibility of Establishing the Health Portion of CHEER*, Children's Action Network, April 2005

Implementation of multidisciplinary teams in other jurisdictions

In the field of services for children who are dependents and wards of the court, there are many advocates for multidisciplinary teams, based on the reported results of improved effectiveness of services and better outcomes[58]. Many states have enacted statutes that allow, and encourage, creation of such teams for child abuse prevention, identification and treatment services. As cited above, California law allows for creation of multidisciplinary teams for services to dependent children and sharing of information and records about those children among team members.

California law includes the following definition of multidisciplinary teams:

> "Multidisciplinary personnel mean any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse." (California Welfare & Institutions Code §18951(d))

The statute identifies eligible multidisciplinary team members including social workers with experience in child abuse prevention, medical personnel with sufficient training to provide health services, psychiatrists, psychologists, therapists and other trained counseling personnel and others. Los Angeles County has created a number of multidisciplinary teams who provide services to children who are under the jurisdiction of DCFS as discussed further in Section 3 of this report.

[58] See National Children's Alliance, National Child Advocacy Center, U.S. Department of Justice (publication: *Forming a Multidisciplinary Team to Investigate Child Abuse,* Mark Els, 1998.

Florida's Multidisciplinary Child Protection Teams

In other states where multidisciplinary teams are enabled by statute, one example worth noting is the State of Florida. It has a structured statewide multidisciplinary Child Protection Team (CPT) program in place with teams located in each of the Department of Children and Families' geographic zones. These teams, led by the State Department of Health's Children's Medical Services division are comprised of several medical professional, social workers, representatives for the State Attorney's Office, a Dependency Court representative, and a representative of the local Sheriff's Office. Psychologists are available as needed.

Suspected child abuse cases reported to the Department of Children and Families are mandated to be referred to these teams for multidisciplinary assessments including medical examinations, forensic interviews, psychosocial assessments, case staffing and psychological evaluations. Risk to the child is to be assessed and interventions recommended. Cases are referred to the Child Protection Teams if they involve certain types of injuries including injuries to the head, burns or fractures, bruises anywhere on a child five years of age or younger, sexual abuse, any sexually transmitted diseases, reported malnutrition and others.

The Florida program was started in 1978 and expanded in 1999 as a result of the reported success of the early teams and due to several child abuse related deaths. In 1999, the legislature established mandatory criteria of cases for referral to the Child Protection Teams.

The Child Protection Teams in each of Florida's zones are comprised of permanent members who meet weekly. They have a detailed policy and procedure handbook which details time frames for their services, roles of each member and reporting relationships with other State and local agencies. Their records are classified as confidential for external entities, but are be shared among all team members. The handbook does not address the issue of access to the child's medical records from prior to their assessment by the Teams. They maintain their own information system where they keep detailed records on the children they have assessed. Performance standards and quality assurance processes are detailed in the program's policy and procedure handbook.

Virginia's multidisciplinary teams laws

Of other states that have created multidisciplinary teams, the Commonwealth of Virginia has enacted statutes that provide local child protective services agencies with more latitude than they have in California regarding sharing records and information. The guiding principle is that the agencies must determine that they are releasing their records to, "a person *having a legitimate interest* when in the judgment of the local department, it is who is the subject of the records"[59] *(emphasis added)*. Persons having a legitimate interest are defined in the statutes as including, "but not limited to (i) any person who is responsible for investigating a report of known or suspected abuse or neglect or for providing services to a child or family that is the subject of a report, including multi-disciplinary teams and family assessment and planning teams…, law enforcement agencies and attorneys for the Commonwealth."[60]

[59] Virginia Code §63.2-105
[60] Virginia Code §63.2-105

Regarding medical records, Virginia law requires that all mandated reporters who maintain records about the child (including physicians and other licensed medical personnel) make, "related information, records and reports available to the investigating agency".[61] It explicitly states that provision of reports and records by a health care provider shall not be prohibited by the Virginia statute[62] pertaining to communications between physicians and patients which limits the information and records that a physician is required to otherwise provide in legal proceedings. Depending on the definition of "related information", this appears to provide broader leeway about medical records that can be requested by child protective services investigators and must be provided by health care providers.

Virginia's statutes expand on what is in place in California by providing broader latitude to the child protective services agencies to define the best interests of the child and share records and information accordingly. The law also appears to indicate that medical records beyond those immediately pertaining to a mandated child maltreatment report can be requested by and must be provided to child protective services investigators.

Conclusion

In sum, the confidentiality of child abuse records is established in federal and state law and County policies and procedures. The same exceptions to these restrictions are included in all three levels of applicable statutes and policies. Of particular note for the purposes of this audit is the exception provided for multidisciplinary teams. DCFS policies in place are consistent with state laws in this regard though they create a number of tasks that have to be performed for routine requests for medical records. There are no specific provisions in the Department's policies for responding to requests from multidisciplinary teams, (even though a member of such a team for children in the child welfare system would likely include a DCFS staff member). To encourage the use of interagency multidisciplinary teams, policies are needed to expedite the extraction and provision of medical history and records in particular for use by DHS staff who is providing medical services to children who are also being served by DCFS.

Recommendations

The Department of Children and Family Services should:

1.9 Amend Department policies to include protocols for expediting release of routine medical histories and information to multidisciplinary teams and DHS medical personnel who are providing services to children under the jurisdiction of DCFS.

1.10 Assign responsibility to a DCFS manager for ensuring and documenting that routine medical histories and information are provided timely to multidisciplinary teams and DHS medical personnel in compliance with the recommended new expedited protocol.

[61] Virginia Code §63.2-1509
[62] Virginia Code §8.01-399, "Communications between physicians and patients"

1.11 Provide reports on a regular basis such as monthly to DHS hospitals on the outcomes of all child maltreatment reports filed for each hospital and other reporting facilities.

1.12 Research with County Counsel, and follow up with the Juvenile Court as appropriate, the possibility of requesting that the Juvenile Court issue blanket orders authorizing release of DHS medical records to DCFS in instances when the parents or guardians have not provided such records to DCFS.

The Department of Health Services should:

1.13 Assign hospital SCAN Teams responsibility for maintaining centralized lists of all child maltreatment reports filed by staff at their facilities and for analyzing and using child maltreatment report outcome data provided by DCFS to adjust training and protocols related to child maltreatment reporting at their facility.

1.5.1 Data collection be expanded to include outpatient clinics in tracking transfer of children from hospitals to clinics which would provide additional centralized list of all child maltreatment reports

1.14 Research with County Counsel laws, regulations and possible options to enable release of medical records to DCFS other than those related to a current incident as part of Department.

The Board of Supervisors should:

1.15 Consider lobbying the State Legislature for changes in law that would provide DCFS and other child protective services agency with discretion in sharing records and data about children in their system based on a determination that such sharing is in the best interests of the child and clarifying that DHS can share other medical records relevant to DCFS even if they are not for the current charge of child maltreatment, as appears to be allowed by Commonwealth of Virginia statutes.

1.16 Request that the CEO assign an assistant to further implement the interagency Memorandum of Understanding that has been adopted by DCFS, DHS, DMH and Probation regarding data sharing across departments. Move to immediately implement data sharing between DHS (mHUB) and DCFS (my CSW) to promote the safety of foster children and their compliance with medical and mental health treatment plans and follow up care.

2. Information technology issues

- Though information sharing between the Department of Children and Family Services (DCFS) and the Department of Health Services (DHS) is legally feasible with certain limitations, the departments' electronic information systems do not enable information or data sharing. As a result, children under the jurisdiction of DCFS frequently receive medical services without their DHS health care provider having their medical history and records.
- DHS medical providers cannot access medical records or information on follow up appointments on DCFS' computer system. DCFS staff cannot electronically access DHS systems to retrieve medical records for children whose parents or guardians have not provided them. In fact, DHS staff can't electronically access many medical records from their own department since it has six separate information systems, each of which is only accessible to staff in certain geographic areas.
- The primary source of medical record information sharing between the two departments currently is the paper based Health and Education Passport, a set of forms and documents compiled in a binder that is supposed to contain the medical history and record of all medical encounters for each child in the DCFS system. This approach is inefficient and ineffective as it requires redundant data entry, the information in the binders is often not current and, in many cases, the binders are not being used at all.
- The medical HUB clinic at LAC+USC Medical Center that specializes in services for abused and neglected children has implemented an electronic information system that could be expanded and linked to the Department's other HUB clinics and, potentially, to DCFS sooner than the large scale information technology projects.
- An alternative system has also been proposed that would link County systems with external sources of information such as MediCal for electronic access to more information on the children being served.

Given the scale and nature of the operations of the Department of Children and Family Services and the Department of Health Services, data and information sharing between the two departments could be greatly enhanced by electronic information systems. The greatest needs for information sharing between the two departments pertain to:

- DHS obtaining medical records and histories for children they are serving who are under the jurisdiction of DCFS. This includes children in foster care and congregate care facilities.
- DCFS obtaining medical records and histories for children either in their system or who are being investigated as potential victims of child maltreatment; and,
- DHS obtaining summarized data on outcomes of suspected child maltreatment reports filed wherever it occurred.

Currently the two departments' information systems do not enable any of these critical areas of information sharing.

DCFS information system

Implemented in 1997, DCFS' Child Welfare Services/Case Management System (known as CWS/CMS) is a statewide system used by the child protective services agencies in all California counties and the California Department of Social Services. Its functions include storing information on the location, demographics and program goals for children and families receiving services from DCFS. It also allows for compilation of data about children, programs and other measures for staff and management review and assessment and, because it is a statewide system, it allows for statewide compilations of program information and comparisons between counties.

Besides basic demographic information, CWS/CMS's case management data is supposed to include information on the details of the abuse or neglect to which each child was subject to, investigation results, their medical and education histories, placements, residences and all petitions filed on behalf of the child, and service plans. Court reports and court orders are also stored in the system.

Confidentiality of records in CWS/CMS is maintained through multiple layers of security including restricted authorization to the network, network monitoring and filtering, data encryption, limitations on staff access based on assignments, centralized user identification monitoring and security auditing and monitoring. There are no electronic interfaces between CWS/CMS and other County agencies such as DHS. To obtain the medical records or history of a DCFS child from the CWS/CMS system, for example, DHS staff have to make a request to a DCFS employee with access privileges for the child to withdraw the data or records, obtain approvals from a Supervising Children's Social Worker and County Counsel and then release the information to DHS.

This current records request process is time consuming and ineffective in situations when DHS health care providers are seeing a child who has just entered the DCFS system but has arrived for their first appointment without their medical history and records document, a not uncommon occurrence. Electronic access to CWS/CMS on demand would provide healthcare providers with this needed information as well the ability for timely monitoring of the child's follow up appointments.

DHS information systems

DCFS staff does not have electronic access to DHS records or information to obtain medical histories and records for children they are serving or investigating. This can present problems in instances when Children's Social Workers have not received such records from parents or guardians of detained children and the child needs to see a health care provider (DHS or otherwise) who then has to make medical decisions without this information. If DCFS staff doesn't have information on where a child had received medical services and wanted to check DHS records, they must make a request to DHS staff which must then conduct a cumbersome and time consuming search. DCFS staff reports it is not unusual for this process to take four to

six weeks, making it useless in terms of providing records for a current medical appointment. Electronic access to DHS records would allow the DCFS worker to acquire a medical history on a timely basis.

An additional complication with the current search process is that DHS medical care staff have the same disadvantage as DCFS in accessing a patient's medical records. In many instances, if they were to attempt to obtain DHS medical records for a patient, they would have to make the same type of request as DCFS staff since DHS medical care providers only have access to records on the information system they use. If their patient received services at a DHS facility using one of the other five DHS information systems, the medical care providers would not be able to access those records. However, this lack of integration of medical records is being addressed[63]

Another complication, beyond the scope of this audit, is that many children in the DCFS system receive services from medical care providers outside of DHS, or may have been seen by a combination of DHS and private providers in the past. This further complicates the ability of DCFS to obtain medical histories and a complete set of records for children in instances when they have not received such records from the child's parents or guardians[64].

Health & Education Passport: Paper-based exchange of medical records

The current process for sharing medical records between DCFS and DHS relies on a paper based system that has proven ineffective. Known as the Health and Education Passport, this set of paper records is supposed to mirror the medical information stored in CWS/CMS for each child. According to DCFS policy, parents or guardians are supposed to provide medical records and information on a standardized form to DCFS staff at the initial hearing for the child, at the direction of the Hearing Officer[65]. This information is then supposed to be entered in to CWS/CMS, from which it is printed out and maintained in hard copy form in a binder for each child. The binder is supposed to contain other key documents such as a MediCal card and medical authorization information.

The Health and Education Passport binder is to be provided to the child's care giver, such as a foster parent, and taken to every medical appointment. The healthcare provider is supposed to review the documents in the binder and provide an update on standardized DCFS Medical Examination Forms[66]. The updated forms are then supposed to be added to the binder and entered in to CWS/CMS when the forms are returned to the Children's Social Worker.

Besides being a very cumbersome manual process, DCFS and DHS representatives and others familiar with the system report it is extremely ineffective due to a lack of compliance at every step of the process. The result is that medical care providers often end up providing care to

[63] The CIO for DHS is creating an enterprise master personal index and an integrated system for data sharing between hospitals.
[64] HUBs as discussed in Section 3 need to be expanded to include foster care and congregate care facilities as well as outpatient clinics as discussed by the VIP Director.
[65] Form JV-255 designed by the Judicial Council of California
[66] DCFS Forms 561(a), (b) and (c) for medical, dental and psychological examinations, respectively

DCFS children without the benefit of basic information such as the child's medical history, maltreatment, immunization records and prescription information. The interagency Memorandum of Understanding (MOU) between DCFS, DHS, DMH, and Probation is a first effort to develop protocols for cross-sharing of information[67].

DHS, DCFS and County plans for information technology improvements and data sharing

The County has included a goal in its Strategic Plan to implement a client-centered, information-based health and mental health services delivery system[68]. To achieve this strategic plan's goal, major upgrades and restructuring of DHS and DCFS information systems are being planned and/or underway. Current efforts include:

1) The establishment of a unique department wide information system and an electronic medical records (EMR) system within DHS that will enable sharing of patient information between all county hospitals, which have different systems, and within the department itself. To accomplish this, an Enterprise Master Patient Index, a unique patient identifier, is being created for all patients within DHS. This entails implementing new software tools to identify each patient within DHS to eliminate duplicate records.

2) The interagency memorandum of understanding (MOU) between DCFS, DHS, DMH and Probation is a first effort to develop protocols for cross-sharing of information[69]. It establishes an operative principle that those who have custody of a minor should have all the health and mental health information they reasonably need to promote the health and safety of these minors, to prevent duplicate health and mental health services and to promote continuity of care.

Implementation of these strategies entails overcoming confidentiality issues (legal restraints), administrative coordination and cooperation between departments in addition to information technology system upgrades.

Replacement of CWS/CMS with a web-based system is being planned by the State of California due to changes in the way child welfare services are being delivered and the need to replace outmoded and difficult to use technologies employed by the current system. One goal for the new system articulated in the September 2006 Strategic Plan for system replacement is,

> "CWS/CMS will support collaboration and information sharing among agencies and partners to ultimately provide a comprehensive "one stop resource" for CWS social workers and other users."

[67] County of Los Angeles, Chief Administrative Office, May 9, 2007, Signed and final memorandum of understanding (MOU) regarding disclosures of health and mental health information to and from county departments which have custody of minors (DCFS, DHS, DMH and Probation).
[68] Goal 7 of the Los Angeles County Strategic Plan
[69] County of Los Angeles, Chief Administrative Office, MOU, May 9, 2007

The timetable for CWS/CMS replacement calls for full statewide implementation by 2011, or in four years

Alternative approaches to more quickly enable information and data sharing between DCFS and DHS

While all signs are that DCFS and DHS will be enabling significantly more information and data sharing in the future, their plans are complex large scale system replacements and restructurings that will each take many years. Sharing records between DCFS and DHS is one of many features of the new systems to be implemented and could be further delayed if either project encounters unexpected schedule setbacks. More immediate approaches should be considered, if cost effective, so that the problems caused by the current lack of information and data sharing between the two departments are addressed sooner than four to seven years in the future, assuming all goes according to plan.

The medical HUB clinic at LAC+USC Medical Center, one of six clinics at the DHS hospitals serving as central medical facilities for children entering the child welfare system, has automated its patient records, tracking and scheduling functions with an information system called mHUB. This system is providing a less elaborate version of the electronic health record planned for all of DHS and as discussed above.

Before mHUB was implemented, DCFS implemented MyCSW, a web-based application that serves as a personalized case management portal for staff, organizing and presenting data from the CWS/CMS system in a more user-friendly "point and click" format. MyCSW does not replace or supplant CWS/CMS, but rather takes data from the system, including medical information and records, and lets the Children's Social Workers organize it in a more flexible and easy to use format.

DCFS is proposing creation of an interface between MyCSW and mHUB (which were both developed by the same company) so that DCFS' Children's Social Workers can electronically submit referrals for medical examinations to a medical HUB clinic and the clinic staff can have electronic access to the child's medical information and history, immunization data, scheduled and missed appointments and other pertinent information downloaded from CWS/CMS and available on MyCSW. Results of the child's visits to the HUB clinics, such as diagnoses, medications, allergies, follow up appointments, etc. would be posted in mHUB and become immediately visible to DCFS staff and would be copied and pasted into CWS/CMS.

The proposed MyCSW/mHUB interface would reduce the need for using the paper-based and ineffective Health and Education Passport system. It would also eliminate the need for redundant data entry as the medical records and documents from either side would be entered once, then cut and paste for sharing with the other party. Information would be available immediately through this system, eliminating the delays associated with obtaining and transmitting paper documents. This interface would enable better medical care as the medical care providers would be able to find out and follow up when a child misses an appointment and the Children's Social Workers would have a more reliable and timely source of information about the medical conditions and appointments for the children they are overseeing.

A further potential enhancement of mHUB is expansion of the system to the other HUB clinics operated by DHS. This would provide all of the HUB clinics with the same benefits as described above for the clinic at LAC+USC Medical Center. Such an expansion would provide additional functionality to the HUB system as it would enable electronic communications between all HUB facilities, which would facilitate inter-HUB scheduling, coordination and follow up appointments. A HUB-wide system would provide a consistent set of patient records across the HUB system, beneficial in situations where a child moves to a different part of the County, for example, and another HUB clinic is more convenient. To the extent more children use the HUB system in the future, their medical history would be centralized and accessible to staff at all HUB facilities.

Electronic patient records in mHUB would also enable compilation of HUB activity data for management assessments of performance and planning for improvements to the system. DCFS has estimated that establishment of an interface between mHUB and MyCSW will cost $743,000, of which $493,000 has already been spent according to the Department's Advance Planning Document Update dated February 20, 2007.

Another less extensive alternative to the DCFS and DHS plans and aimed at facilitating information sharing between DHS and DCFS is a proposed information system called Child Health and Education Electronic Record (CHEER). CHEER is an electronic medical records system for foster children proposed by the nonprofit Children's Action Network. A more ambitious system than the proposed MyCSW/mHUB interface, CHEER would also be web-based and would link CWS/CMS and the DHS HUB clinics. However, it would also interface with the State MediCal database to provide a critical source of past medical records of many children now in the DCFS system. The system would reportedly be interoperable with electronic medical records in private medical offices. Parents, foster and other caregivers for the children in the DCFS system would also be able to access the system and obtain medical records and information for children in their care.

CHEER would require a cadre of workers to collect and manipulate the information obtained from various input sources. However, the impact of this would be offset by the amount of time the County is already expending trying to locate and organize medical records of children in the DCFS system, not to mention a non-quantified amount time spent by health care providers providing duplicate or unnecessary services because they don't have full records of the children they are seeing.

The Children's Action Network has estimated that development of a pilot CHEER system linking CWS/CMS, two HUB clinics, MediCal and other appropriate databases could be completed in nine months with seven part-time staff dedicated to the project. The estimated cost for this pilot is between $1.5 and $2 million. Estimates of cost of full implementation are not presented in the Children's Action Network document detailing the recommended system[70].

[70] *A Report on the Feasibility of Establishing the Health Portion of CHEER (Child Health and Education Electronic Record) for Los Angeles County Foster Youth*, Children's Action Network, April 2005

Conclusion

Though there is a great need for sharing medical information and records about their mutual clients, information systems in place at DHS and DCFS do not enable electronic sharing of such data. Manual systems in place, particularly the Health and Education Passport, are inefficient and ineffective. Delaying data sharing for the additional 1 to 2 years needed to develop CHEERS is not in the best interest of children in foster care or at risk for foster care.

A major step has been made with the memorandum of understanding established between DHS, DCFS, Probation and DMH regarding disclosures of health and mental health information to and from County departments which have custody of minors (DCFS, DHS, DMH and Probation).

Recommendations

The Board of Supervisors should:

2.4 Implement mHUB and myCSW links between 1) all medical HUBS 2) medical HUBS and DCFS. Further assessment of CHEERS may be useful for inclusion of education and emancipation information in the county-wide data base.

2.5 Direct the County Internal Services Department to work with DHS and DCFS to assess which of the alternative short term interface systems would be most able to be integrated with planned upgrades and improvements in DHS and DCFS information system.

2.6 Request that the CEO appoint an assistant to coordinate the implementation of new information technology and data sharing between DHS and DCFS

3. Interdepartmental collaboration, information sharing and the HUB clinics

- Several initiatives have been implemented in recent years to facilitate interagency information and data sharing between the Department of Children and Family Services, Department of Health Services and other County departments in the interest of improved services for abused and neglected children. For a variety of reasons, their effectiveness has been mixed. Enhanced Countywide management oversight appears to be needed to improve the effectiveness of these and other efforts.
- One such initiative that has been implemented in a number of settings is multidisciplinary teams, which are designed in part to provide better coordinated services and better outcomes through inter-departmental information sharing, as allowed by state law. Medical HUB clinics specializing in services for abused and neglected children have been established at each Department of Health Services hospital. Each clinic is supposed to be staffed by a multidisciplinary team comprised of DHS healthcare providers and administrative staff, DCFS staff and Department of Mental Health staff.
- While the HUB clinics represent a significant advance in services for abused and neglected children, not all of the expected advantages of these facilities are being realized. Most of the records transferred between HUB clinics and DCFS are paper based and sent by fax rather than electronically. HUB staff report spending an inordinate amount of time trying to obtain medical records and information from DCFS, scheduling and confirming appointments and following up on missed appointments and ongoing medical services. DCFS staff report that they do not always receive records of medical visits or prescribed follow up care from the HUB clinics. DCFS has not yet assigned a staff person to the relatively new Harbor/UCLA HUB clinic so a full multidisciplinary team is not in effect there.
- Interagency coordination and data sharing is not working as well as possible between DCFS and DHS due to technology limitations and a need for enhanced management oversight of the effectiveness of the two departments' coordination and information sharing.

In an ongoing attempt to better coordinate services between County departments for abused and neglected children, a number of initiatives have been implemented in recent years in Los Angeles County aimed at bringing together information and resources from a variety of sources in the interests of providing more coherent and effective services. Each has offered improvements in service approach and delivery and each has had limitations.

Manual and automated Health and Education Passport

The Health and Education Passport, discussed in Section 2 of this report, was an attempt to consolidate documents from healthcare providers and educational institutions for children in the child welfare system in a single compilation so that each child's social workers, medical care providers, educational institutions and caregivers would have access to the same current information. When there were changes in any of these service providers, the records would remain in the passport (a binder) and be available to their successors, thus avoiding discontinuities in service and redundant data collection.

Limitations to the Health and Education Passport, as identified in Section 2, include lack of compliance with system protocols by almost all of those with a role in maintaining it. Parents and guardians often do not provide their child's medical records and history at the time their child is initially detained, children and their caregivers often do not bring their Passport binders with them to medical appointments, healthcare providers often do not complete the forms DCFS requests that they prepare summarizing each medical encounter and the records and information that are completed are frequently not entered in to CWS/CMS by DCFS staff.

Automating the Health and Education Passport was attempted by the County in 2002 in an interdepartmental proposal for a system called Child Health and Education Passport System (CHEPS). Approval of the proposed system was denied by the federal government which was being asked to pay for 75 percent of the system's cost. The reasons for denying the request included the arguments that CHEPS would duplicate the functionality of CWS/CMS (DCFS's primary computer system), that the federal government had already invested $250 million statewide in CWS/CMS, that a cost-benefit analysis was not conducted to demonstrate the need for the proposed system, that CWS/CMS was already underutilized in California, and that the State was not involved in analyzing the CHEPS proposal. The State subsequently reviewed the CHEPS proposal and concluded they could not support it either since, among other reasons, it, "will merely automate a process that does not function properly"[71]. As a result of CHEPS or any other automated system never being approved, the ineffective paper based manual Health and Education Passport is still in place today.

Inter-Agency Council on Child Abuse and Neglect

The Board of Supervisors established the Inter-Agency Council on Child Abuse and Neglect (ICAN) in 1977 to serve as the official County body charged with coordinating the development of services for the prevention, identification and treatment of child abuse and neglect. The Council established a Policy Committee comprised of twenty-seven County department heads and numerous experts and community representatives, an Operations Committee as a working body of member agencies and community council representatives, a Data/information Sharing Committee to address those issues and other committees and working groups. ICAN is a public-private partnership that receives County funding and grants and funds from external sources.

ICAN plays many roles in the County related to coordination of services for abused and neglected children. Convening its committees provides forums for all key departments involved in the provision of services to these children to share information, ideas and operational issues. ICAN also compiles hard copy data from all of these departments into a single annual document that provides a detailed look at services, caseloads and operational issues pertaining to abused and neglected children for each department. However, these reports do not include the steps as provided in the DCFS response to the 2001-2002 Civil Grand Jury audit in assessing the quality of child abuse investigations. Briefly summarized, they are 1) accurate data collection 2) analyze current data 3) write report 4) create action plan 5) implement, and 6) evaluate after six months[72].

[71] Letter from David Janssen, Chief Administrative Officer, Los Angeles County to each member of the Board of Supervisors, July 22, 2002.

[72] DCFS Response to 2001-2002 Civil Grand Jury Audit, "Assessing the Quality of Child Abuse and Neglect Investigation" August 21,2002 Synopsys #69 Supervisor Knabe's 2002 motion: Grand Jury.Submitted to Los Angeles county Board of Supervisors by Marjorie Kelly, Interim Director, DCFS.

ICAN has advocated for various changes in County practices and protocols related to services for neglected and abused children and has affected State legislation on the same topic. It serves in an advisory capacity, and it is not a part of the present efforts of interagency sharing and creation of the medical HUB system.

Although ICAN's original intent was to serve as the official County body charged with coordinating the development of services for the prevention, identification and treatment of child abuse and neglect, it does not have administrative authority over County departments.

Multidisciplinary teams

Numerous multidisciplinary teams have been established in the County to provide services for abused and neglected children or those suspected of being victims of abuse and neglect. Multidisciplinary teams are defined by state law as:

> "…any team of three or more persons who are trained in the prevention, identification and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. The team may include but not be limited to:
>
> (6) Psychiatrists, psychologists, marriage and family therapists, or other trained counseling personnel.
> (7) Police officers or other law enforcement agents.
> (8) Medical personnel with sufficient training to provide health services.
> (9) Social workers with experience or training in child abuse prevention.
> (10)Any public or private school teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee."[73]

Multidisciplinary teams do not have to be from different departments but often they are. As discussed in Section 1 of this report, with some limitations, multidisciplinary teams are allowed to share information and records from each team members' home department that are otherwise classified as confidential. This is consistent with the legislative intent of these teams to provide more integrated, coordinated and appropriate services based on having more information from a variety of disciplines about the child.

Examples of multidisciplinary teams that have been established in the County to serve children suspected of or found to be victims of abuse and neglect include:

- **Hospital SCAN Teams**

  These multidisciplinary teams serve as a resource for assisting in investigations of Suspected Child Abuse and Neglect (SCAN) at each of the DHS hospitals. Comprised of a mix of hospital personnel from different disciplines and, in some instances, representatives from external agencies, their role is to assist any healthcare worker or other mandated reporter at a hospital in assessing the circumstances and medical conditions of patients help determine if it is appropriate to report the case to DCFS as a case of suspected child abuse. The Teams also

[73] California Welfare & Institutions Code §18951(d)(1-5)

help prepare reports and accompanying documents for DCFS. The role of the SCAN Teams at Harbor/UCLA and LAC+USC Medical Center was reviewed for this audit. The benefits of the Teams assuming the role of reviewing the outcomes of their facility's reports of suspected child abuse and neglect is discussed and recommended in Section 2.

- **Child Death Review Teams**

  Since 1978, Los Angeles County has been reviewing child deaths using an inter-agency team in cases in which the cause of death is undetermined or an accident or a caregiver is suspected of causing the death[74]. ICAN is the coordinator of this team. The team is comprised of representatives of DCFS, DHS, the Coroner, Department of Mental Health, County Counsel, Sheriff, District Attorney, Los Angeles Police, Los Angeles City Attorney, County Office of Education, California Department of Social Services and representatives of the medical community.

  Pertinent records from all team members' departments pertaining to the child and family are shared with the other team members. This extensive set of record and data sharing is allowed by the federal Child Abuse Prevention and Treatment and Adoption Act (CAPTA) and local department policies and protocols. Medical records can be released in cases of child abuse investigation according to state law, though there might be more restrictions on these than for releasing child abuse records.

  While the level of allowable record and data sharing is undoubtedly heightened by the severity of the situation of a child death, the Child Abuse Prevention and Treatment and Adoption Act also allows for, "public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a fatality or *near fatality*" (emphasis added)[75].

[74] In 1997, California law established a state Child Death Review Council and Child Death Review Teams, mirroring the practice in Los Angeles County.

[75] 42 U.S.C. 5106a(b)(2)(A)(x)

- **Team Decision Making**

  Team Decision Making (TDM) is a process by which DCFS Children's Social Workers (CSWs) convene a group of individuals related to a DCFS referral or ongoing case to discuss placement decisions. DCFS policy and procedures regarding TDM dated December 2005 state that individuals that may be invited to a TDM include:

  - Immediate family members
  - Extended family members
  - Community members
  - Other support persons
  - Children's Social Worker
  - Supervising Children's Social Worker
  - Current service providers

  All TDM meetings are led by a neutral DCFS facilitator. Public Health Nurses are, at times, invited to these meetings, but not often. DCFS staff report that Public Health Nurses are called to such meetings if the CSW deems it important for the child's medical needs. According to DCFS policy, TDM is to be conducted "when any placement decision is contemplated." Examples of situations that could trigger a placement decision include when:

  - Emergency response staff are trying to decide whether to remove a child due to safety considerations;
  - A seven-day notice is issued for the removal from a placement;[76]
  - A child/youth is being considered for placement/replacement; and.
  - A child/youth is being considered for reunification.

  Anecdotal evidence indicates that Caws do *not* routinely follow policy regarding TDM. When data was requested on effectiveness/outcomes of the process, DCFS staff reported that no such data or studies regarding TDM exist at this time.

- **HUB clinics**

  HUB clinics have been established at each of DHS' six hospitals to serve as specialized clinics for children who are being investigated as possible victims of child abuse or neglect or have been found to be victims and are under the custody of DCFS. The clinics generally serve two main purposes: 1) initial assessments of children who have just entered the child welfare system; and 2) forensic examinations and ongoing services in some cases for children who are being investigated as possible victims of child maltreatment or have experienced possible abuse or neglect after being detained.

  The structures of the Hubs vary but the concept is to have a multidisciplinary team of healthcare providers, mental health workers and DCFS staff all at one site where they can conduct intake and forensic interviews, conduct mental health assessments and conduct

[76] According to DCFS staff, seven-day notices may be issued by a foster home, requesting that a child or youth be removed for cause.

medical examinations. If the child is detained or already in the child welfare system, the results of these processes are to be used to prepare a service plan, possibly with the involvement of parents, caregivers and others involved in the care of the child.

Visits and staff interviews at the HUB clinics at Harbor/UCLA and LAC+USC Medical Clinics[77] found dedicated staff, many of whom have specialized skills in working with children and assessing child abuse and neglect. The policy of sending all children entering the child welfare system to one of the HUB clinics allows for standardized interviews and medical and mental health assessment processes and documentation. The multidisciplinary teams allow for a more comprehensive approach to services for the children and a better opportunity for staff to follow up on the services provided.

Staff report that there have been some positive developments when the multidisciplinary teams at the HUBs work together and successfully share information and records. However, a number of problems were identified at both clinics pertaining to the HUBs, including:

- the frequent absence of shared records and information between the departments;
- time-consuming manual paper-based information exchanges instead of electronic communications, not uncommonly resulting in lost records;
- the absence of a DCFS team member at Harbor/UCLA; and,
- inefficient processes and poor communications regarding transferring records and following up on medical care and services.

The HUB clinics at LAC+USC and Harbor/UCLA both have multiple components, including one that primarily provides initial assessments for children entering the child welfare system and one for forensic examinations and possible ongoing services for children suspected of being maltreated who may or may not already be under the jurisdiction of DCFS. The initial assessments often take place with little notice. For example, children entering the system under the age of three or at high risk are supposed to receive their initial medical assessment within 72 hours of being detained. Children over three and not at high risk are supposed to be seen within 30 days of initial placement.

Ideally, medical histories and records of these children would arrive before or with them to be used during the medical assessment. However, they are often not available at the time the children are seen for all types of visits at the HUBs. As stated earlier in this report, the absence of such documents presents problems as the healthcare providers must make medical decisions without the benefit of the child's immunization records, or identification of the child's allergies, existing medication prescriptions, and medical conditions.

DHS staff does not have access privileges to DCFS' computer system (CWS/CMS) so they must either rely on DCFS staff out-stationed at the HUBs to obtain the records electronically or on the child's Children's Social Worker or caregiver to bring them in paper form to the appointment. Neither of these approaches have proven satisfactory because: the records are often not electronically accessible because they have never been entered in to CWS/CMS; the out-stationed DCFS workers are only on duty Monday – Friday during normal business hours whereas children enter the system on all days at all hours; and, the Children's Social

[77] The HUB clinic at LAC+USC Medical Center is also known as the Violence Intervention Program (VIP) clinic.

Worker and caregivers often don't have the hard copy documents to bring to the appointments, or they don't always remember to bring them. Keeping track of these paper records and making sure they are entered into CWS/CMS gets further complicated as children change placements, change social workers, change medical care providers and move to different parts of the County.

Following up after medical appointments presents additional challenges for HUB staff. HUB medical staff report that they are required to fax documentation of the medical encounters to the Children's Social Worker to ensure confidentiality and because they don't have electronic access to computer systems at the Department. DCFS staff report that they frequently do not receive these faxed documents. Given the nature of the transmission method, it is not surprising that this isn't the most reliable method, not to mention its questionable ability to ensure confidentiality of the records.

Scheduling HUB appointments and follow up care is another problem. Since the departments do not have joint electronic access to a scheduling system, appointments are arranged by telephone and fax for the HUB clinics for forensic examinations and ongoing care. Referral appointments are also often made for care at other DHS clinics by HUB staff. It reportedly takes a number of phone calls by HUB staff to confirm appointments yet, even with these efforts, there is a high rate of no shows for all appointments. DHS staff report that DCFS' Children's Social Workers are responsible for appointments but in practice they do not always keep or reschedule appointments, resulting in unproductive time with empty appointment slots at the clinics.

Monitoring follow up care is difficult for the same reasons. If the HUB staff recommends follow up specialty care at another clinic, they cannot easily find out if the appointment has been kept or what the outcome is. Such information is not readily accessible to them with the current communication protocols between the two departments and frequently requires making numerous phone calls and requests to DCFS staff as the case moves through the system. Staff at the LAC+USC clinic report that they have no record of follow up care for approximately 60 percent of the children they see.

The full impact of the multidisciplinary team is not being achieved at the Harbor/UCLA HUB because a DCFS staff person has not been assigned there since it opened last year. Apparently DCFS has been in the process of determining the appropriate classification to send to the HUBs and is considering Public Health Nurses instead of Children's Social Worker, the current choice. Until this issue is resolved, the Department has chosen to leave the Harbor/UCLA position vacant.

There is some inconsistency in the roles of the multidisciplinary teams at the HUBs. At Harbor/UCLA, the team has never been fully constituted due to the vacant DCFS position. At LAC+USC, the out-stationed DCFS workers act in a liaison capacity but the team does not function in a case management capacity.

A number of jurisdictions with reports of multidisciplinary team effectiveness such as San Diego County have developed "standing" teams, i.e., teams that follow a case throughout its duration in the system. In this way, the team ensures consistency of approach, that information continues to be shared between departments and there is a multidisciplinary approach to follow up services as the child's needs change over time.

Expanding and improving HUB approach

Despite the problems cited above, DCFS staff expressed great confidence in, and support for the HUB system. They believe that HUB staff are very knowledgeable about children served by DCFS, and are most competent to serve them. They also cited examples of compassionate and caring service at the HUBs. For example, one CSW said she received a call from a HUB staff person six months after the child was seen at the HUB, inquiring about the child and how they were doing.

HUB clinic administrators interviewed at LAC+USC and Harbor/UCLA expressed a desire to have PHNs assigned to their facility. They indicated that these individuals would be helpful in "triaging" DCFS cases and appointment requests and in ensuring that children receive the follow-up care they need. In addition, given their medical training, these individuals would likely provide important expertise as part of the multi-disciplinary teams.

The VIP HUB at LAC+USC was cited as one of the best in interviews with DCFS and DHS staff and many believe that its model should be replicated throughout the County. The VIP clinic, the first HUB created, is one of the best funded and most developed sites. Documents provided by VIP administrators and interviews with them indicated that one reason for the success of the organization is that it created a separate 501(c)3, a nonprofit subsidiary, through which it raises funds for special programs and additional services. In addition to its emergency and forensic operations for DCFS children.

Though the VIP and other HUBs were routinely praised for doing excellent work for children and families, DCFS staff reported there are not enough HUBs. They cited occasions of waiting long hours, all night in one case, for children to be seen. VIP administrators reported that it could take two to four weeks to get an appointment to their non-emergency clinic.

Table 3.1 below shows the total number of HUB visits between July 2006 and February 2007. DHS staff reported that the initial medical examinations of detained children was below target for all seven months. The target is 837 exams per month, and actual number of exams conducted per month fell below target by anywhere from 63% to 26%.

Table 3.1
Total HUB Clinic Visits
July 2006 – February 2007

Type of Service Provided	Number of HUB Visits
Forensic Evaluation for Newly Detained Children (Includes Mental Health Screen)	2,159
Initial Medical Exam for Newly Detained Children (Includes Mental Health Screen)	4,149
Follow-up Medical Care for Detained Children	1,466
Medical Services for Non-Detained Children	939
Total HUB Visits	**8,713**

Source: DHS document

Documentation provided by DCFS shows that in Calendar Year 2006, 67,767 investigations were initiated by DCFS. According to DCFS administrators, the Agency currently has between 20,000 and 25,000 children in foster and/or kinship care. That means that at any given time, DCFS is serving tens of thousands of children who are detained, non-detained or under investigation. Given the magnitude of these numbers, and given the high level of need that these children tend to have, they would be well served by a medical system such as the one that exists in the HUB system.

While the HUB system has six DHS sites serving the entire County, DCFS has 14 offices serving the same area. Given these facts, it appears that the current HUB system needs to expand its capacity, both within the existing structure, and by duplicating the structure in other areas of the County. For example, the VIP HUB serves all of the eastern portion of the County, including the San Gabriel Valley. This creates access difficulties for CSWs, parents and caregivers, especially in emergency response situations. VIP administrators report they are currently working on opening a site in the San Gabriel Valley.

The Department's intent for the HUBs is that all children who have been detained will have a common point of medical entry to the system and that children needing a forensic examination can get all their interviews accomplished in one place. The general criteria for children seen at the HUBs are for those recently detained and those injured while under the custody of DCFS. Borrowing from the State of Florida approach, described in Section 1, more specific criteria and priorities for the HUBs could be established to make the best possible use of these centralized multidisciplinary team clinics. For example, any incident of possible abuse or neglect, including sexual abuse, while a child is in the system could trigger an examination at a HUB clinic. Or, DCFS could direct its most medically needy children, known as the medically fragile in the Department, exclusively to the HUBs to ensure that they will receive a high level of care and a multidisciplinary case management approach.

Discussions with administrators from the Medical Placement Unit of DCFS and with PHNs that serve that unit indicate that these children often are seen by physicians outside of the HUB

system, without any involvement by HUBs. These children are the ones with the most medical needs in the DCFS. They have such major medical issues as "oxygen support, urinary catheterization, renal dialysis…and other medical or surgical procedures or special medication regimens" according to DCFS policy documents. With all parties in the system agreeing that HUBs are the most equipped to manage DCFS cases, it would be in the best interest of the children and the families for the HUBs to at least oversee the medical services provided in these cases.

The DCFS Medical Placement Unit provided data for Medically Fragile Cases in Calendar Year 2006. This data, which reflected "End-Month Child Cases Which Were Considered Medically Fragile Cases" indicates that on average, DCFS had 895 such cases at any time in 2006. With the magnitude of overall cases managed by the Department and by the HUBs, this number appears to be capable of being absorbed by the HUB system though it may require some enhancements to HUB staffing and resources.

Conclusion

While electronic access to a scheduling and records system would improve the flow of data and information between the HUB clinics and DCFS, there are some fundamental management problems with the current processes and procedures as well.

The problem with past interagency efforts is that management accountability is diffused in many cases; there is often no single manager accountable for the success of the initiative.

There is a need for higher level management oversight of interdepartmental coordination of information and data sharing. There is also a need for greater management accountability for making these efforts work in each of the departments involved. ICAN does not have the authority for this administrative function and is not involved with ongoing and future plans for data sharing. The absence, at present, of someone, such as an account manager at DCFS for sharing medical records information (until EMRs are in place) is an example of a critical function that is currently missing. This situation, as it exists, prohibits the sharing of medical information in a timely fashion.

The concept of "standing" multidisciplinary teams that provide ongoing case management services has been reported as effective in other jurisdictions. Applying this concept to the HUB clinic staff would enhance their role and provide greater assurances of consistency in services and the benefits of continual information and data sharing for those children.

The Child Abuse Prevention and Treatment and Adoption Act allows for disclosure of the findings of information about the case of child abuse that results in fatality. The same standards of information and record sharing to near fatality investigations, it is possible that more could be accomplished in terms of preventing fatalities from occurring and near fatalities from reoccurring. ICAN is in the process of developing a protocol for investigations of near fatalities.

Recommendations

The Board of Supervisors should direct the Chief Executive Officer to:

3.9 Appoint an assistant to assume countywide management responsibility for ensuring the effectiveness of Countywide interagency collaboration and data sharing efforts directed toward abused and neglected children, including the enhanced support of HUBs to include POE and MAT services.

3.10 Assign Public Health Nurses to staff the HUB clinics in addition to Children's Social workers.

The Board of Supervisors should direct DCFS to:

3.11 Assign Public Health Nurses to staff the HUB clinics rather than Children's Social Workers since all children in the DCFS system are already assigned a social worker who could still serve on the multidisciplinary teams for the children in their caseload; and

3.12 Define the multidisciplinary teams at the HUBs to serve as "standing" teams responsible for direct services and/or ongoing monitoring of cases and to be comprised of HUB physicians, Public Health Nurses and mental health providers with rotating members for each case consisting of the child's biologic parents and/or caregivers, Children's Social Worker, foster care providers, congregate-care providers and others.

The Board of Supervisors should direct DHS to:

3.13 Collaborate with DCFS, Department of Mental Health and other key stakeholders to expand the existing system as necessary to ensure that eventually all or most children in the DCFS system can be served by the HUBs. All children should initially be assessed by HUBS and DCFS and DHS should provide additional staff to adequately provide case management services at each HUB.

The Board of Supervisors should direct DCFS and DHS to:

3.14 To develop policies and procedures that give priority for HUB clinic services to children at high risk or with higher medical needs such as Medically Fragile cases in the form of direct services when this is the best medical option available or in the form of case management if the children need specialist care outside of the HUB structure. Enhance existing HUB services to provide expanded access to appropriate care for all medically fragile cases through either direct service or case management and referrals to community providers.

3.15 To have ICAN integrated within DCFS to enable it to coordinate data collection throughout the County so that it can continue to maintain its ongoing review of child deaths.

3.16 Create an interagency pilot program as an extension of the hospital SCAN teams (or some interim system) to assist in investigating suspected child abuse and neglect for all the dependents in DCFS.

4. Public Health Nurses

- Public Health Nurses (PHNs) in the Department of Children and Family Services play a key role as liaisons to the Department of Health Services and other health care providers who provide medical services to children under the jurisdiction of the Department. The PHNs are central to the Department's current efforts to obtain medical histories and records for all children in the system, disseminate them to their medical providers and keep them updated in the Department's computer system.
- The effectiveness of the PHNs has been compromised by the fact that more than half of them report to a manager in the Department of Public Health rather than a DCFS manager and thus adhere to a different set of operating policies and procedures and performance appraisal measures. The PHNs have two different definitions of the types of cases for which they are responsible. Certain case situations are not covered by either definition.
- The medical record data entry function assigned to the PHNs is key to quality medical care for the children in the DCFS system but many records are not getting entered or made available to medical care providers when needed. DCFS managers report that they cannot direct the PHNs who report to the Department of Public Health to perform this task since they have no authority over them. The PHNs report that the data entry workload is unmanageable. There is no single DCFS manager with total responsibility for managing data entry and the other key case management functions that are supposed to be performed by the PHNs.
- Much of the data entry work performed does not appear to be the "highest and best use" of PHNs' skills and abilities. Freeing up these workers' time from the data entry function would enable them to provide more valuable services to the Department, such as those related to ensuring the best medical care for children in the system.

The Public Health Nursing Program at DCFS consists of 135 positions. Sixty-one of these positions are employees of DCFS and 74 are employees of the Department of Public Health (DPH). The DCFS Public Health Nurses ultimately report to the Medical Director of the Department whereas the Department of Public Health positions ultimately report to that Department's Medical Director of the Child Health Disability Prevention Program (CHDP). The table below reflects the breakdown of staff:

Table 4.1
Public Health Nursing Staff at DCFS

Classification	DCFS Staff	Public Health Staff	Total
Nurse Manager	1	1	**2**
Public Health Nursing Supervisor	5	6	**11**
Public Health Nurses	45	67	**112**
Intermediate Typist Clerk	9	0	**9**
Senior Typist Clerk	1	0	**1**
Total	**61**	**74**	**135**

Source: DCFS

The DPH Public Health Nurses are assigned to DCFS on the basis of a Memorandum of Understanding between the two departments. These positions, along with the DCFS Public Health Nurses, perform a key role in terms of information sharing and inter-agency coordination between DCFS and DHS.

The DCFS Public Health Nurses are funded through the DCFS budget, and are governed by the policies and procedures of DCFS. The DPH Public Health Nurses are funded by the State Health Care Program for Children in Foster Care (HCPCFC), funded through the State General Fund with matching funds from the Federal Medicaid program administered by the California Department of Health Services. Therefore the duties of these Public Health Nurses are governed by this stream of funding and a different set of operating policies and procedures. For example, a letter jointly signed by administrators of the California Department of Social Services and DHS[78] states that:

> "The funding for this program does not allow the PHNs to provide direct services to children. The activities of the PHNs are limited to those administrative functions eligible for federal matching funds through the Medicaid (Title XIX) program."

Below are the primary duties of the DPH Public Health Nurses:

- Administrative Medical Case Management—These duties are intended to represent 75 percent of the day-to-day work of the PHNs, and include:
  - obtaining health care documentation from DHS and other medical care providers;
  - to assess health care services and appropriate follow up;
  - assessing and verifying medical information prior to entering it into CWS/CMS;
  - facilitating the sharing of medical information with health care providers;
  - participating in developing health plans for the children in out-of-home placement with the CSW;
  - participating in case conferences or multidisciplinary teams.

[78] The Department of Public Health is now a separate County department but at the time this letter was signed it was part of the Department of Health Services.

- Intra/Interagency Coordination, Collaboration, and Administration—These duties are intended to represent 10 percent of the day-to-day work of the PHNs, and include:
  - collaborative activities that involve planning and resources development with other agencies for the delivery of healthcare services;
  - providing technical assistance to other agencies regarding children's health care service needs.

- General Administration—These duties are intended to represent 5 percent of the day-to-day activities of the PHNs and include:
  - collaborating with Children's Medical Services staff regarding program administrative and nursing policies;
  - participating in the distribution of program specific information;
  - reviewing pediatric and foster care research.

- Skilled Professional Medical Personnel (SPMP) Training—These duties are intended to represent 5 percent of the PHNs' day-to-day activities, and include:
  - attending training by or for skilled professional medical personnel;
  - participating in program planning and policy development regarding administrative case management.

- SPMP Program Planning and Policy Development—These duties are intended to represent 2 percent of the PHNs' day-to-day activities and include:
  - providing consultation and technical assistance to social workers and probation officers regarding healthcare resources and prioritizing health care needs;
  - developing and distributing health-related professional education material.

- Quality Management—These duties are intended to represent 3 percent of the PHNs' day-to-day activities and primarily involve conducting quality assurance activities.

The duties of the DCFS Public Health Nurses (PHNs) adhere to a separate set of policies and procedures designed specifically for them, but modeled after the duties of the DPH PHNs. These policies and procedures discuss the conditions under which a "Joint Response Referral" is required, i.e., a coordinated response between the PHN and Children's Social Worker. The joint response is required for these nurses if the referral involves a case of a child 36 months or younger. This may be a visit to a home, school or office; but the visit is not mandatory unless there are "serious medical problems such as Diabetes, Shaken Baby Syndrome, failure to thrive, etc., and/or allegations of severe neglect"..

PHNs are assigned to specific offices, and to specific Children's Social Workers within each office. Each PHN works with several Children's Social Workers.

In general, the DCFS PHN program appears to be a positive addition to the services provided to children and families in the DCFS system and the positions play a key role in facilitating information sharing between DCFS and DHS to the extent it currently exists. However, the program is experiencing operational difficulties as described below.

Reporting relationships and measuring outcomes

The reporting relationships of the PHNs appear to be hindering their effectiveness and accountability. As mentioned above, the DCFS PHNs and their supervisors report to a Nurse Manager, who reports to the DCFS Medical Director. The DPH PHNs and their supervisors report to a Nurse Manager who reports to the Medical Director of the DPH Child Health Disability Prevention Program. These reporting relationships reflect the "chain of command" for these employees and govern their separate performance appraisal systems. A review of pertinent documents and interviews with PHNs, their managers and other DCFS staff and administrators indicates the two reporting structures causes difficulties relative day-to-day operations.

DCFS administrators report that they often don't know what the PHNs are doing, and, due to their separate reporting relationship, cannot require them to perform certain duties, regardless of what they believe are the priorities of their office. These administrators state that while they can and do hold their Children's Social Workers accountable for the cases and caseloads they carry, they have no such authority over the PHNs. This not only creates miscommunication regarding the PHN's day-to-day activities, but it hinders coordination and ultimately the overall effectiveness of the office.

In interviews, PHNs and their managers confirmed the validity of the DCFS administrators' concerns. When asked what channels exist for Children's Social Workers, their supervisors and DCFS administrators to discuss and work out operational difficulties related to the day-to-day utilization of the PHNs, they reported that they were not aware of any *systematic* approaches to this. There are some informal channels, but these depend on the personal relationships that may or may not exist between administrators and supervisors.

In addition, DCFS administrators stated that the PHNs often complain that their caseloads are too high. One PHN supervisor reported that the caseload of her staff is between 520 and 570 cases per worker (these numbers have not been verified). DCFS administrators interviewed said that while PHNs are technically assigned to that many cases, the actual cases for which they are accountable is not clear. As mentioned above, DCFS policy requires a "consultation" be made in the case of *referrals* involving infants or children who are 36 months or younger. While DCFS nurses are required to abide by these policies, and their caseload could be tied to these requirements, the DPH nurses do not have the same requirements.

One reason for the difficulty in assessing caseload is that the Public Health Nursing program does not systematically document their caseload activities and outcomes. When such information was requested, two separate sets of information were provided; one from the DCFS and one from the DPH PHN managers. Calendar Year 2006 data was requested, but this information did not exist for either program. The DCFS data had been lost, with exception of December 2006 data. The DPH data only existed for half of the year, July through December.

The information that was provided is not focused on outcomes, but on activities. For example, the data includes the number of consultations or meetings, but not measurable results in children's overall health. There are no outcome measures for the key PHN duties related to

information sharing between DCFS and DHS: obtaining healthcare documentation; assessing and verifying medical information prior to entering it into CWS/CMS; and, facilitating the sharing of medical information with healthcare providers. The two departments are capturing some performance data that is similar and some that is different, making it difficult to evaluate both sets of PHNs on a consistent basis. (The DPH PHN Manager said that a committee has been set up to recommend PHN outcomes, but they are just beginning their work.)

It was difficult to calculate PHN "caseloads", activities or outcomes from the documents provided. PHNs generally do not "carry" cases in the same way that Children's Social Workers (CSWs) do. They generally work on a "consultative" basis with the CSWs, and generally rely on the CSWs to initiate contact regarding a case. At that point, they will work with the case in the manner described in the responsibilities listed above. Once a referral or case is "stabilized" medically or closed, they stop work on it. One exception to this is "medically fragile" or "special needs" children. These children are assigned to the Medical Placement Unit, once a case is opened, and the PHN follows the child until the case is closed.

Differing Regulations Create Confusion

As mentioned above, the DPH PHNs operate under the State Health Care Program for Children in Foster Care regulations, whereas the DCFS PHNs are governed by DCFS policies and procedures. This has created some confusion about the roles and responsibilities of the two types of nurses working at DCFS. In interviews with the nurses themselves, they broke down their duties as follows:

- DCFS Nurses work with the "front-end" of cases, i.e., during the investigation phase of a *referral*, or investigation of potential child abuse or neglect; and
- PHN Nurses work with the "back-end" of cases, i.e., once a referral is substantiated and becomes an open DCFS case.

In practice this breakdown of responsibilities creates confusion about which PHNs are responsible for working referrals and/or cases at any given time. A memo signed by administrators from the California Departments of Social Services and Health Services provided the following definition of children to be served by the DPH Public Health Nurses: "a foster child is a court dependent placed with a relative, foster family, foster family agency, or group home."

However, according to interviews with PHN managers, this meant that some children are left in a "limbo" state, wherein they are "dependents of the court" with an open case (i.e., "back end") but living at home. These children are not eligible for service by either type of Public Health Nurse, because they are not in the "front end" or investigation stage of the process, but are not placed outside the home, as required under the State definition for DPH Public Health Nurse service.

It is not clear how DCFS cases under these circumstances are affected in terms of information sharing but since the primary duties of the Public Health Nurses includes the collection and dissemination of children's medical records to healthcare providers, it would appear that the

cases that don't meet the criteria for Public Health Nurse service may not be receiving the same level of service as more stable cases and may thus be receiving a lower level of service in terms of the collection and dissemination of their medical records to their healthcare providers.

In an attempt to address this issue, a memo to PHN Supervisors working at DCFS from the Medical Directors of DCFS and the Child Health Disability Prevention Program as well as the Nurse Managers of each of these Departments revised the assignments of the two types of nurses as follows:

DCFS Public Health Nurses

- Children in home of biologic parent(s), regardless of service component
- Post Adoption Services

DPH Public Health Nurses

- Children not in the home of biologic parent(s), regardless of the service component
- Adoption Units

However, this does not appear to have resolved the issues that it was attempting to address. For one thing, children go back and forth from their biologic home to foster homes as their cases are managed through the DCFS system. According to the above criteria, that means the PHN serving them would have to change every time their location changes. In addition, the placement of the child may or may not be associated with their being a "court dependent." For example, a child may be placed outside the home as part of a "Voluntary Maintenance" case, in which a child is temporarily placed with a relative but is not declared a court dependent. Similarly, a child who is placed in the home may still be declared a "court dependent." The DPH PHN could not serve either one of those cases, according to the State definition of a foster child.

Data Entry

As indicated above in the list of their duties PHNs are responsible for "assessing and verifying medical information prior to entering it into CWS/CMS." This has evolved into the overall responsibility of entering *all* medical and dental data available on each child into CWS/CMS. (DCFS PHNs also enter data into CWS/CMS, but they are supported by nine clerical staff who assist with this function, according to a DCFS PHN manager.) Data entry is a key function in terms of information sharing between DCFS and DHS, as discussed in previous sections of this report, and has significant impact on the quality of medical care provided.

The DPH Public Health Nurses interviewed stated that Children's Social Workers and their Supervisors place large stacks of medical records on the PHNs' desks and expect that they will input these into CWS/CMS. They said that PHNs are overwhelmed by this task. They estimated that they spend between 75 and 80 percent of their time on data entry and on requesting records from various medical providers at DHS and other medical facilities.

Despite this, it appears that many medical records do not get entered into the system. DPH PHNs reported that they give priority to the "consultative" function, and to entering information for cases for which they provided consultation to the Children's Social Workers. They believe that duties such as coordinating with medical providers regarding a child's care, linking the children and families with community medical services and following up with caregivers should take priority over entering data on cases with which they've had no contact.

While this appears to be reasonable prioritization, the data entry function also is very important, and in fact, is key to data and information sharing between DCFS, DHS and private medical providers and it affects the quality of medical care the children receive. As discussed earlier in this report, if medical records or history are missing from CWS/CMS and are not made available to healthcare providers when they see a child, they have to make medical decisions without the benefit of knowing the child's immunization record, allergies, medications and other medical conditions. PHNs and CSWs recognize this, but the current work structure has become a source of tension between them. It is not clear why the PHNs have discretion over the functions they perform or what steps DCFS management has taken, or can take, to ensure performance of this key function.

Los Angeles County Public Health Nurses generally are required be licensed by the state of California as Registered Nurses. This licensure requires between two and four years of college. They earn between $67,356 and $85,428 annually. If all Public Health Nurses spent approximately 50 percent of their time entering data into CWS/CMS, the effort would cost taxpayers between $3,771,936 and $4,783,968 annually.

Los Angeles County Intermediate Clerk Typists (ITCs) earn between $29,556 and $37,584 annually. If the data entry function were restructured so that the majority of data entry were done by ITCs or a similar clerical position, the County could save between $2,116,800 and $2,679,264 annually. Additionally, the function likely would be accomplished more systematically, improving the overall quality of services to children, and easing the tension that currently exists regarding this issue.

Conclusion

The Public Health Nurses in DCFS are key to information and data sharing with DHS and other private medical providers and bring a medical perspective to the Department's case management function. Their effectiveness is compromised due to management and organizational issues. Over half of the Department's Public Health Nurses (PHNs) are employees of the separate Department of Public Health and report to different managers than the DCFS PHNs, adhere to different policies and procedures and have a different performance appraisal system. To the extent they exist, outcome measures for the two sets of PHNs are inconsistent. The medical records data entry function that PHNs are supposed to perform is not being accomplished and DCFS has not assumed a management oversight role for these positions.

Recommendations:

The Board of Supervisors should direct the Chief Executive Officer to appoint an assistant to oversee the Departments in order to:

4.8 Amend the Memorandum of Understanding between DCFS and the Department of Public Health, if necessary, to allow for dotted line reporting relationships so that Public Health Nurse supervisors to report to DCFS District Office/SPA Regional Administrators, including allowing those Administrators to provide input to the PHN performance evaluations;

4.9 With input from DCFS line staff and managers, establish and begin collecting data for monthly reports to the Regional Administrators using a consistent set of activity and outcome measures for which all PHNs can be held accountable, including measures of their effectiveness in obtaining healthcare documentation from DHS and other medical care providers, assessing healthcare services provided, assessing and verifying medical information prior to entering it into CWS/CMS, and facilitating the sharing of medical information with healthcare providers;

4.10 Assign a single DCFS manager responsibility for ensuring and documenting that the key case management function of entering medical records into CWS/CMS for all cases by either Public Health Nurses or other appropriate staff so that the records are available when needed for children's medical appointments.

The Board of Supervisors should direct DCFS and the Department of Public Health to:

4.11 Consider an alternative system of medical record data entry, such as using Intermediate Typists Clerks or a similar County classification for the majority of routine cases so that Public Health Nurses are utilized in a more efficient and effective manner but would still be available for assisting with interpretations of the more complex medical information and records obtained by DCFS for entry in to CWS/CMS.

The Board of Supervisors should direct the Department of Public Health to:

4.12 Apply for a waiver from the state Health Care Program for Children in Foster Care program definition of foster child, enabling its PHNs to serve any child who is referred to, or is part of, an open case at DCFS;

4.13 Collaborate with DCFS to amend their Memorandum of Understanding to enable all Public Health Nurses to serve any child in the DCFS system who is referred to, or is part of an open case at DCFS;

4.14 Evaluate the situation in other counties to see if Public Health Nurses are restricted from serving certain children in the DCFS system and, depending on the findings, amend its definition of foster child to enable PHNs to serve any child welfare referral or open case.

5. Prevention and Data Sharing

- DCFS is currently enhancing its resources and services directed to child abuse and neglect prevention activities and intend to continue to do so in the future. The Department implemented a pilot Point of Engagement program in 2004 that provides for more community-based services for families who are experiencing problems, are assessed as low risk of future instances of child abuse and neglect and are willing to make changes and improvements. Team Decision Making is one aspect of this program that provides a multidisciplinary team approach to supporting these families.
- The Board of Supervisors directed County staff in 2006 to expand prevention efforts with a "holistic, integrated approach to services" that address root causes of child abuse or neglect. While the motion and resulting DCFS concept paper on the topic does not specifically address health services, the paper does establish healthy communities as one outcome target for the Department's prevention efforts and recommends that the County's Chief Administrative Office assume responsibility for interdepartmental coordination.
- The move toward coordinated interdepartmental services as part of child maltreatment prevention services speaks to the need for well orchestrated information and data sharing between DCFS and DHS particularly for families who may need health services as part of their family improvement plan. As DCFS proceeds with plans to expand its prevention efforts, the importance of well managed information and data sharing with DHS should be included as a program objective, with outcome measures established to ensure that it is occurring.

Current Child Maltreatment Prevention Efforts at DCFS

DCFS's prevention efforts are relatively new. The Department began implementing a pilot program called Point of Engagement (POE) in 2004. POE, which is being implemented in the Compton and Wateridge (South Los Angeles) offices, is a preventive, family-centered approach that makes maximum use of community based organizations in its response to family needs. It is designed to support the Department's goals of safety, reducing detentions and increasing permanency.

In late 2006, the Children and Families Research Consortium (CFRC) conducted an evaluation of the POE[79]. This evaluation, which was a comprehensive qualitative analysis, provides a

[79] According to its website, the Children and Families Research Consortium is a group formed by DCFS and the Interuniversity Consortium (IUC). The IUC is a group of five local universities engaged in providing training services to DCFS. The CFRC is focused on "enhancing DCFS capacity to analyze and

detailed background about POE, its relationship to State of California policy initiatives, and the results from 17 interviews and three focus groups with staff and administrators from the Compton and Wateridge offices, as well as a focus group with representatives from Shields for Families, a key community-based nonprofit organization which has been collaborating with DCFS on POE.

According to the CFRC report, POE is consistent with the State of California's Child Welfare Services Redesign Plan developed in 2003. In this plan, there are three paths that could be used effectively in serving families that come to the attention of the child welfare system as follows:

"*Path 1*: Community Response is used when a family is experiencing problems but the situation does not meet statutory definitions of abuse or neglect. Instead of being turned away without any assistance, families are linked to services in the community through partnerships with local organizations.

Path 2: Child Welfare and Community Response may be used when the report meets statutory definitions of abuse and neglect. County staff assess that the child is safe and at low to moderate risk of future harm and the family is likely to make changes and mitigate risk voluntarily. The county agency works with the family and community-based organizations to identify strengths and needs. If the family is unwilling to make needed improvements or the situation deteriorates, endangering the child, the case would be re-referred to the child welfare agency.

Path 3: Child Welfare Services Response is used when the child is not safe and is at moderate to high risk of continued abuse or neglect. Actions may be taken with or without the family's consent, court orders may be sought and criminal charges may be filed. Social workers seek to engage families more fully and to work with other county agencies to provide focused services. This path is most similar to the child welfare system's traditional response."

DCFS's POE pilot has focused on "evaluated out" and "inconclusive" referrals, i.e., allegations regarding a family that are called into the DCFS Hotline. Some calls to the DCFS Hotline are "evaluated out" when, according to a systematic assessment by the Hotline telephone worker, the referral *does not* meet "California Department of Social Services guidelines" for an in-person response. If a referral is forwarded to the SPA/District Office, an Emergency Response worker may, after systematically investigating it, deem it to be "inconclusive", i.e., evidence is insufficient to "substantiate" the allegation. Both of these situations trigger a POE case for the Compton and Wateridge offices during the pilot, which is still ongoing, partially funded by a grant from First 5 L.A.

Once POE is triggered, the family is referred to local community services. To date, many of these services have been provided by Shields for Families, which is the actual recipient of the First 5 L.A. funds. One of the main goals of POE is to "prevent a referral from becoming a

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use data to support planning and decision-making, developing research priorities and a long term research agenda, and facilitating partnerships with universities and other research organizations to expand knowledge about public child welfare."

DCFS case," according to the CFRC report. Families are often engaged in Team Decision Making (TDM), which is a process by which a family, Children's Social Workers, community based organizations, and other professionals and potential support systems are engaged in a facilitated discussion regarding a plan for the child's safety and family's overall well-being. This may involve assisting with housing, employment and finding financial resources for the family. It might involve counseling and other social supports. The solution depends on the results of the TDM.

Involvement in POE is voluntary on the family's part, and the family is required to sign forms that indicate its voluntary nature. If a family lapses in its efforts or there are signs of potential abuse or neglect, the nonprofit service agency and/or the CSW may refer the family back to the DCFS system for further investigation.

The CFRC evaluation found that POE has demonstrated many strengths, which it recommends be evaluated more systematically using quantitative data and methods. Among these, it found that:

- DCFS Emergency Response workers focus on preventing detention and immediately securing services for families;
- DCFS Emergency Response workers have more contact with community-based agencies, and relationships between DCFS and community-based organization staff are now more open;
- A quantitative evaluation done on an earlier version of POE (then known as differential response) found that of 118 families served, less than one third returned to DCFS within one year; and
- Families help come up with the plan, whereas in the traditional DCFS model, CSWs came up with the plan or applied a "boilerplate" service plan.

Some of the challenges identified in the report included:

- While the program depends heavily on them for its success, some community based organizations expressed concerns that they are not sufficiently engaged in the development of DCFS policy and program planning;
- The contracting process does not adequately provide for uninterrupted services to be provided by the collaborating community based organizations; and
- There is a need for more Spanish-speaking and otherwise culturally competent staff at DCFS and collaborating community-based organizations to reflect demographic shifts in the County.

Future Prevention Activities

According to a concept paper provided by DCFS, the Board of Supervisors approved a motion in March 2006 that directed the Chief Administrative Office (CAO), in partnership with the

Children's Planning Council, the Commission for Children and Families, the Interagency Council on Child Abuse and Neglect (ICAN), and the New Directions Task Force to "develop a plan for a comprehensive prevention initiative." Quoting from the motion, the concept paper states that the plan should recognize that:

> *"…[T]o prevent harm to children, we must look beyond the boundaries of DCFS and focus on creating a holistic, integrated approach to services that strengthen and support families. This can be addressed by examining the root causes of child abuse or neglect, such as poverty, lack of job training, mental illness, substance abuse, lack of child care, inadequate understanding of parenting responsibilities and the importance of early childhood development.*

Though not specifically identified, the provision of health services would clearly be a key component of the approach to prevention endorsed in the motion. The concept paper, which is dated October 11, 2006, details the structure by which such an initiative would be implemented. Populations targeted would include the following:

- Vulnerable families outside County systems;
- Hotline-reported cases that are evaluated out or classified as unfounded ;
- Hotline-reported families with unsubstantiated circumstances;
- Voluntary Family Maintenance cases;
- Families with children in out-of-home placement;
- Foster families and relative caregivers;
- Adoptive families; and
- Youth in the child welfare or probation systems

Objectives to be pursued include:

- Increased social support and decreased social isolation;
- Development of community leaders;
- Increased Community enrichment;
- Increased family economic opportunity and success;
- Increased parental resilience;
- Increased children's social and emotional competence;
- Improved family structure and functioning;
- Improved system of care; and
- Improved capacity of County departments to work in partnership with community-based contractors to achieve objectives and outcomes.

The concept paper also addressed the needs of families, as directly expressed by them. Among the needs cited were:

- Skills needed to get better jobs;
- Access to employment;
- Access to affordable housing;
- Access to affordable, quality child care;

- Access to affordable transportation;
- Reduction of gang violence and peer pressure;
- Family friendly schools with high standards and expectations;
- Opportunities to experience support from peers;
- Access to educational and recreational after school programs; and
- Desire for help in gaining parental competence and confidence.

Recommendations are included in the concept paper for the roles of key parties:

- The CAO's Service Integration Branch would provide inter-departmental coordination;
- DCFS, in collaboration with key county and community stakeholders, would identify and select existing Family Support Networks that would participate in the effort;
- The Children and Families Research Consortium would identify initial communities to be served, with a focus on communities with a high number of DCFS referrals;
- The Children Planning Council's SPAs would work to strengthen the Family Support Networks; and
- The New Directions Task Force would make policy decisions and recommendations to the Board of Supervisors regarding plan design and implementation.

The inclusion of inter-departmental coordination in the recommendations confirms the need for information and data sharing between departments including DCFS and DHS as part of this prevention initiative. Key outcome areas identified are:

- Healthy communities
- Strong Families
- Safe Children

The outcome of "healthy communities" speaks to the need for information and data sharing between DCFS and both the Department of Health Services for personal health issues and the Department of Public Health for community public health issues. Discussions with DCFS administrators indicate that the process of implementing this approach is beginning. Early this year, DCFS centralized its prevention efforts into the Community-Based Support Division, which is under Service Bureau Four. According to the Deputy Director of this Service Bureau, the Division currently has 50 authorized positions. According to an organization chart provided by Service Bureau representatives, the Division is comprised of the following four units:

- Education and Mentoring;
- Family Preservation;
- Family Support; and
- Child Care.

A brief description of the Division's activities provided by Service Bureau representatives states that the "primary focus" is to provide, through contracts with community partners, services to children and families that come to the attention of DCFS.
One of the goals of the Division is "to create an integrated and seamless approach in the delivery of services and resources across and within each unit towards meeting the Department's three

outcomes areas, prevention strategies and the county's goals of child and family well-being (#5) and services integration (#6)." The description goes on to state that in the area of prevention, "The Division has the lead for crisscrossing both within and outside the Department."

Another indication of work toward the prevention goals described in the concept paper is that Hotline Regional Administrator has been asked to develop questions that would help to identify families that would be good candidates for the Department's planned prevention efforts.

Conclusion

DCFS is enhancing some its resources and efforts directed to child abuse and neglect prevention activities. Key components of its current and future efforts are a multidisciplinary team approach to providing services to families at risk of child abuse or neglect and interdepartmental coordination. While this approach will involve many County departments and community-based organizations, the need for well organized information and data sharing between DCFS and DHS as far as the provision of personal health services is concerned will be central to the success of these efforts. The interagency memorandum of understanding between DCFS, DHS, DMH and Probation is a first step in this endeavor of data sharing.

Recommendations

The Board of Supervisors should direct the Chief Executive Officer to appoint an assistant to oversee the Departments efforts to:

5.6 Conduct the quantitative evaluation recommended in the Children and Families Research Consortium report and include the Department's other prevention activities such as the activities of the Community-Based Support Division;

5.7 Evaluate POE as part of the integrated service. This will guarantee inclusion of the medical and forensic assessments and extend the connections of mHUB with my CSW to enable monitoring of intervention/prevention strategies.

5.8 Use DCFS data base linked with mHUB (or DHS data base) to monitor safety of children identified as "at risk" (i.e., children identified early or brought to DHS but not detained) to determine effective strategies to prevent children from abuse and mandated intervention by DCFS.

5.9 Involve the Department's Public Health Nurses in Point of Engagement Team Decision Making process and other planned prevention activities to ensure a source for information and data sharing with the Department of Health Services clinics and other healthcare facilities regarding families served through the prevention activities; and

5.10 Designate specific SPA/District Offices to be served by specific Community-Based Support Division staff to ensure that prevention services are provided Department-wide and that performance results can be tracked by each Department office.

APPENDIX A – ACRONYMS

CAO	Chief Administrative Officer
CAPTA	Child Abuse Prevention and Treatment and Adoption Act
CDSS	California Department of Social Services
CJG	Civil Grand Jury
CEO	Chief Executive Officer
CFRR	Children and Families Research Consortium
CHDP	Child Health Disability Prevention
CHEER	Child Health and Education Electronic Record
CHEPS	Child Health and Education Passport
CIO	Chief Information Officer
CPT	Child Protection Team
CSW	Children's Social Worker
CWS/CMS	Child Welfare Services/Case Management System
DCFS	Department of Children and Family Services
DHS	Department of Health Services
DMH	Department of Mental Health
DPH	Department of Public Health
EMR	Electronic Medical Records
HCPCFC	Health Care Program for Children in Foster Care
HIPAA	Health Insurance Portability and Accountability Act
HUB	Hospital based clinics providing services for abused and neglected children under the supervision of DCFS
ICAN	Interagency Council on Neglect and Abuse in Los Angeles County
ITC	Intermediate Clerk Typists
IUC	Inter University Consortium
LAC/USC	Los Angeles County/University of Southern California Hospital
MAT	Multidisciplinary Assessment Team
mHUB	Information system of tracking, scheduling and electronic records
MOU	Memorandum of Understanding
myCSW	Electronic Interface for Children's Social Worker
PHN	Public Health Nurse
POE	Point of Engagement (community based service for families)
SCAN	Suspected Child Abuse and Neglect (hospital-based team)
SPA	Service Planning Area
SPMP	Skilled Professional Medical Personnel
SW	Social Worker
TDM	Team Decision Making
VIP	Violence Intervention Program

APPENDIX B - CGJ QUALITATIVE FACT FINDING MEETINGS AND INTERVIEWS

MEETINGS AND INTERVIEWS

- (3) Meetings with Director and Medical Director
- Meeting with Representatives from District Attorney Office Domestic Violence
- (3) Meetings with ICAN
- Meeting with Deputy Planning and Oversight, DHS,
- Visited Eastlake Juvenile Facility
- (2) Meetings with CIO LA County and Information Technology personnel
- (3) Interviews with Social workers, including Emergency Response Supervisor
- (2) Interview, Presiding Judge and others, Edelman Children's Court

DOCUMENTS REVIEWED

- DCFS – Prevention Plan (2002)
- Judge Michael Nash's Standards for Social Workers' Court Reporting
  The Superior Court, Juvenile Division, January 9, 2003
- ICAN – Death Review Report 2005
- ICAN Annual Report on Child Abuse & Neglect 2005
- ICAN/National Center on Child Fatality Review Program
  "Suspicious Child Death and severe non-fatal injury
  review -California and Regional Training, October 25, 2006, Universal Sheraton.
- ICAN Child Abuse and Neglect Protocol, June 8, 2006
- Information presented by City Attorney
- Data on child deaths provided by ICAN
- DCFS Medical Directors report to Grand Jury January 11, 2007

SPEAKERS from Los Angeles County

- Auditor/Controller
- Director, DHS
- Presiding Judge, Edelman Children's Court
- Deputy Director, Probations
- Director, Human Relations Commission
- Civil Rights activist, gang violence
- Community Services & Seniors
- District Attorney

PARTICIPATION

- Day of Mentoring Children in Foster Care – Pierce College
- Department of Public Social Services Toy Loan Program
- Attendance NEXXUS/ICAN "Child Fatality Death Review Conference"– Universal City
- Pat Brown Institute, Symposium "Health and Violence", California State University, LA.

APPENDIX C - REFERENCES

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Disaster Preparedness

Before and After

Disaster Preparedness Committee

Richard Lorne Davis, Chair

John Hackney
Lewis Hastings
Hannah Margolis
Sandra Lee Mohr
James Corbett Tasker
John Visser

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

DISASTER PREPAREDNESS – BEFORE AND AFTER

EXECUTIVE SUMMARY

Los Angeles County has a population of approximately 10 million people, and in past years has experienced extensive devastation due to fires, floods, earthquakes and civil unrest. In view of the world political situation and the instability of other nations and insurgencies, the ongoing threat of terrorist attacks is also a matter of grave concern to the populace.

The Office Of Emergency Management (OEM) was established by Chapter 2.68 of the County Code, with responsibility for organizing and directing the preparedness efforts of the Emergency Management Organization of Los Angeles County. OEM is designated as the day-to-day Los Angeles County Operational Area coordinator for the entire geographic area of the County, which is home to 88 Cities and various other, unincorporated territories.

The 2005-2006 Civil Grand Jury, in the process of investigating the County's preparedness for disasters, prepared its Final Report entitled "Emergency Communication – Are We Ready". That Report contained a number of specific recommendations, to which OEM provided Responses as provided by law. Seven of those Recommendations were deemed feasible, and OEM indicated with specificity the actions it would be taking to implement its Responses.

METHODOLOGY AND PURPOSE

In conformity with its Continuity responsibilities, the 2006-2007 Civil Grand Jury formed an investigative Committee to look into disaster preparedness issues, and in particular, to address OEM's progress relative to its promised and/or proposed courses of action to be undertaken, along with any definitive timelines for completion. Attached hereto as Exhibit A is a list of 7 follow-up points of inquiry as to said pending projects, which was submitted to OEM in February, 2007. This list ultimately elicited responses from OEM, attached hereto as Exhibit B.

After reviewing Exhibit B, the Committee concluded from those Responses that only in the area of Ham radio operations did there appear to have been any real semblance of progress. In fact, there was little clarity as to just what had been accomplished since August, 2006, when OEM's Responses to the previous Final Report were generated; further, that any timetables for completion of promised action appeared to be non-existent.

The Committee concluded that a direct communication approach was needed under the circumstances, and a meeting was scheduled with the County CAO and OEM management. This meeting was for the express purpose of obtaining more definitive answers from OEM and a "real time" assessment for the completion of the seven recommended items in question.

Attached hereto as Exhibit C is an outline of the Committee's position with respect to said meeting which occurred on May 10, 2007, and which formed the basis for the Committee's questions. On that occasion, in addition to rather vague and inconclusive responses to most of our inquiries, certain supplemental documentation was promised by OEM, none of which has been received to date.

CONCLUSION

As suggested elsewhere herein, and as reinforced by said rather non-productive meeting, the Committee was left with the feeling that for all of OEM's appearances and representations to the contrary, that there has been and continues to be a serious and definite lack of any sense of urgency on the part of OEM in helping to prepare the County for contingent disasters occurring possibly sooner than later. All of these failures and lack of immediacy are of grave concern to the Civil Grand Jury and to the County it serves as a watchdog over Departments designed to serve and protect the interests of its citizenry.

Our research has shown that the City of Los Angeles, as a governmental entity, has a far more comprehensive grasp of the problems at hand, and has taken constructive actions to meet its responsibilities. The time for OEM to perform likewise is long past due.

The Civil Grand Jury, therefore, recommends that if OEM is to ever realistically function as a viable part of County government, it requires some stronger leadership in order to correct and/or to implement what needs to be done, and without delay. This is a matter of principles and not personalities, and the stakes are too high to ignore.

EXHIBIT A

FOLLOW-UP POINTS OF INQUIRY BY THE 2006-2007 CIVIL GRAND JURY DIRECTED TO THE LOS ANGELES COUNTY CHIEF ADMINISTRATIVE OFFICER REGARDING RESPONSES TO THE 2005-2006 CIVIL GRAND JURY'S RECOMMENDATIONS IN ITS FINAL REPORT ENTITLED "EMERGENCY COMMUNICATION – ARE WE READY"

1. (a) The Response to the 1st Recommendation concerning the reallocation of Staff resources and funds to the Office Of Emergency Management (OEM) to expand efforts that address resident preparedness reported that OEM will be adding 5 staff members in 2006, one of whom would be assigned to work on the Emergency Survival Program (ESP).

   (b)The inquiries are as follows: (i) Whether the 5 new staff members are in place; (ii) Who has been assigned ESP responsibilities, (iii) What are the details of such Program, and (iiii) What are the duties of the other 4 new staff members.

2. (a) The Response to the 2d Recommendation regarding the employment of social marketing approaches to design and acquire necessary resources for a strategy for the preparation of County residents for emergencies reported firstly, that OEM had applied for a $250,000 grant from Homeland Security (HS) to fund a marketing campaign to promote emergency preparedness, expected in November, 2006, and secondly, that OEM was working jointly with the City of Los Angeles to develop proposal details to identify the appropriate firm(s) for this project.

   (b) The inquiries are as follows: (i) Whether the HS grant was received, (ii) Whether the joint efforts of the County and City have resulted in finalization of the proposal described, and (iii) Whether any firm has been designated for working the proposal, and if so, which one(s).

3. (a) The Response to the 3d Recommendation regarding the allocation of staff resources and funds to prepare basic information materials in other languages to supplement Public Health (PH) messaging, and the entry into translation contracts requiring a 4-hour turnaround of message translation in a PH emergency situation, reported that OEM was working to develop a Joint Information Center (JIC) for the public's benefit..

   (b) The inquiries are as follows: (i) Whether the JIC is currently a functioning entity, (ii) Whether PH is presently involved in the message translation project, and (iii) If so, to what extent.

4. (a) The Response to the 4th Recommendation regarding the establishment and pursuit of policies and procedures to encourage employees to have emergency plans and supplies in place for their families reported firstly, that the Department Emergency Coordinator (DEC) and the Building Emergency Coordinator (BEC) routinely receive and pass on to employees and their organizations information

regarding emergency plans, and secondly, that routine emergency drills and postings of emergency preparedness information were done County-wide.

(b) The inquiries are as follows: (i) Whether the routine described is currently in operation, (ii) Whether the routines have been changed, altered or otherwise amended, and (iii) If so, to what extent.

5. (a) The Response to Part (b) of the 5th Recommendation regarding assistance to animal owners in an emergency situation reported that the Los Angeles County Animal Care And Control Department (ACACD) was the lead agency in routinely providing animal care information, including emergency animal evacuations.

   (b) The inquiries are as follows: (i) Whether there exists a documented standard operating procedure concerning the above matters, (ii) Whether it has been amended since the last Response on this subject, and (iii) How the ACACD disseminates this type of information to the public.

6. (a) The Response to the 6th Recommendation regarding Citizen Volunteers who provide assistance to neighbors and emergency responders reported that OEM was negotiating a contract with UCLA to develop an informational Website for Community Emergency Response Team volunteers..

   (b) The inquiries are as follows: (i) Whether the UCLA contract has been finalized, (ii) Whether a Volunteer registration list has been developed and is in use, (iii) The general response by Volunteers to so register, and (iiii) The training programs in place for registered volunteers.

7. (a) The Response to the 7th Recommendation regarding incentives to ham radio operators to become involved in emergency response activity reported that the Los Angeles County Sheriff's Department (LASD) was the lead agency on alert, with numerous programs involving ham radio operators, and that OEM was to confer with LASD to explore the feasibility of using these civilian assets.

   (b) The inquiries are as follows: (i) Whether there has been any development over the past year which encourages ham radio operators to become involved with the emergency communications process, (ii) What incentives have been offered to them, and (iii) What has been the general response by ham radio operators to become a part of disaster response operations.

EXHIBIT B

County of Los Angeles
CHIEF ADMINISTRATIVE OFFICE
713 KENNETH HAHN HALL OF ADMINISTRATION • LOS ANGELES, CALIFORNIA 90012
(213) 974-1101
http://cao.co.la.ca.us

DAVID E. JANSSEN
Chief Administrative Officer

March 29, 2007

Civil Grand Jury
Criminal Courts Building
210 W. Temple St., Room 11-506
Los Angeles, CA 90012

ATTN: Robert E. Sax, Foreperson

2005-2006 GRAND JURY FINAL REPORT FOLLOW-UP

This correspondence is in response to your request for follow-up information on recommendations listed in the 2005-2006 Grand Jury Final Report. There has been considerable progress made on those recommendations. We appreciate your continued interest, commitment and support of the County's disaster preparedness efforts.

1. **INQUIRIES: (i) Whether the 5 new staff members are in place; (ii) Who has been assigned ESP responsibilities, (iii) What are the details of such Program, and (iiii) What are the duties of the other 4 new staff members.**

   The Office of emergency Management (OEM) has not yet hired a staff member to work on the Emergency Survival Program (ESP). However, a Job Opportunity Bulletin has been released by the Department of Human Resources to solicit applicants for the position. It is anticipated that this vacancy will be filled in the very near future. The OEM Public Information Officer (PIO), who is the former ESP manager, continues to handle the ESP responsibilities in the interim.

   The primary duties of this position are to: a) serve as the Program Manager for the Emergency Survival Program (ESP) public education campaign; b) develop and coordinate public education and outreach strategies, plans, processes and procedures; c) develop communications products and activities such as newsletter articles, and public service announcements; d) provide leadership for the 15-county ESP Coordinating Council with respect to the development and coordination of all ESP related materials; and e) coordinate the work activities of the ESP Funding, Marketing, and Publications Subcommittees.

EXHIBIT B

2. **INQUIRIES: The inquiries are as follows: (i) Whether the HS grant was received, (ii) Whether the joint efforts of the County and City have resulted in finalization of the proposal described, and (iii) Whether any firm has been designated for working the proposal, and if so, which one(s).**

OEM was successful in acquiring $250,000 in State Homeland Security Grant Program (SHSGP) funds to conduct a marketing campaign to promote emergency preparedness. OEM has met with the City of Los Angeles on numerous occasions to collaborate on this project. A Strategic Planning Workshop between OEM and the City of Los Angeles was held on March 7-9, 2007 to continue these discussions.

In addition, CBS Outdoor has been chosen as the marketing firm that will be utilized to launch this campaign. OEM is in the process of finalizing a Delegated Authority Agreement (contract) and expects to complete this process within the next few weeks.

3. **INQUIRIES: The inquiries are as follows: (i) Whether the JIC is currently a functioning entity, (ii) Whether PH is presently involved in the message translation project, and (iii) If so, to what extent.**

A location for the Joint Information Center (JIC) has not yet been identified. However, OEM has been in meetings with the Los Angeles County Sheriff's Department (LASD) to identify an appropriate facility. OEM and LASD have conducted site visits to other permanent JIC facilities in Utah and Oregon and are planning a visit to the State's JIC in Sacramento to help them better understand what will be required to obtain, equip and staff such a facility.

OEM, with the assistance of a paid consultant, LASD and other Public Information Officers (PIOs) within the County, has amended the County's Emergency Public Information Plan (EPI), to include JIC protocols and procedures. A series of Team Training Workshops for County PIOs were held in September and November 2006. Two more sessions will be held in May and June 2007. The processes and procedures for establishing a JIC were discussed at these workshops.

Public Health advised that they do not have a blanket contract for translation services in place. They do have a process for such services, but it may take up to 24 hours. Public Health routinely works with OEM in translating and disseminating public education material on disaster preparedness.

EXHIBIT B

4. **INQUIRIES: The inquiries are as follows: (i) Whether the routine described is currently in operation, (ii) Whether the routines have been changed, altered or otherwise amended, and (iii) If so, to what extent.**

The Department Emergency Coordinators (DEC) and Building Emergency Coordinators (BEC) programs are ongoing. OEM is in the process of updating the BEC Manual, in coordination with County Fire. The manual should be updated by May 2007.

Additionally, OEM, in coordination with the DECs, is developing a BEC Train the Trainer program to ensure the efficient and sustainable delivery of this training.

5. **INQUIRIES: The inquiries are as follows: (i) Whether there exists a documented standard operating procedure concerning the above matters, (ii) Whether it has been amended since the last Response on this subject, and (iii) How the ACACD disseminates this type of information to the public.**

There is currently no documented Standard Operating Procedure regarding animal response and rescue. However, the Los Angeles County Animal Care and Control Department, in conjunction with OEM and Veterinary Public Health are currently developing a countywide emergency response plan and supportive standard operating procedures for animal response and rescue. Current efforts at distributing emergency preparedness materials throughout the County include: Los Angeles County Animal Care and Control distributes emergency preparedness brochures for horse owners through County shelters; Los Angeles County Veterinary Public Health distributes emergency preparedness brochures for pet owners throughout the County at various dog parks and health fairs; OEM is currently revising a bulletin on pet preparedness and plans to distribute it countywide through its Emergency Survival Program (ESP).

6. **INQUIRIES: The inquiries are as follows: (i) Whether the UCLA contract has been finalized, (ii) Whether a Volunteer registration list has been developed and is in use, (iii) The general response by Volunteers to so register, and (iiii) The training programs in place for registered volunteers.**

The original UCLA contract to create the volunteer website has been signed and completed. However, an amendment to further develop the website is pending. The amendment provides for the following functions:

- Funding to create a website user's manual
- Hosting and maintenance of the website
- Training of staff to utilize and further enhance the site
- Assist with publicity to increase public usage

EXHIBIT B

The volunteer website database will contain a roster of Community Emergency Response Team (CERT) members who voluntarily register with the system. Those who are interested in CERT training can also locate training opportunities near their home. The website also facilitates in matching potential volunteers with appropriate agencies which will facilitate matching volunteer skills and/or location with the appropriate agency or function.

7. **INQUIRIES: The inquiries are as follows: (i) Whether there has been development over the past year which encourages ham radio operators to become involved with the emergency communication process, (ii) What incentives have been offered to them, and (iii) What has been the general response by ham radio operators to become part of disaster response operations.**

Volunteer Ham radio operators are registered as Disaster Service Workers and organized and led under the LASD Disaster Communications Service (DCS). DCS operators have been included in regular LASD and OEM training and exercise programs. OEM includes recognition of DCS as an available emergency resource in its briefings to agencies and officials. DCS has received equipment upgrades including:

- The addition of a new mountain top repeater
- New ID Cards
- The repair of mountain top repeaters
- Radio and Emergency Alert System upgrades at all Sheriff Stations
- A new cache of commercial grade hand-held radios for use in emergencies and specials events
- New Command Post vehicles

DCS has also increased their cooperation with the American Red Cross and supports their evacuation centers and shelters as needed. DCS conducts monthly drills and issues certificates of recognition for volunteer service.

If you have any further questions or comments regarding this matter, please contact Michael J. Brooks at (323) 980-2261.

Sincerely,

DAVID E. JANSSEN
Chief Administrative Officer

DEJ:MJB:jl
O:\OEM_Staff\Brooks\Grand Jury\FollowupGrandJury3-27-07.doc

EXHIBIT C

Outline for Committee Meeting (Disaster Preparedness) with County CAO on 5/10/07.

Preamble: With all due respect, the Committee believes from the answers dated March 29, 2007, given in response to our written follow up inquiries, submitted February 14, 2007, as to the progress made by OEM with respect to its responses given in August, 2006 to the 2005-06 Civil Grand Jury's Final Report, that there appears to be a clear lack of any sense of urgency in accomplishing what was essentially promised, namely:

1. That 5 new staff members would be hired in 2006 (for which funding was available) to work the Emergency Survival Program. As of March 07, none have been hired; why not?
2. To what use has the $250,000 grant from Homeland Security been put? In 2006, OEM was already working with the City of Los Angeles to develop a social marketing program, being a strategy for the preparation of county residents for emergencies. As of March 07, OEM had met with the City on numerous occasions and even held a strategic planning workshop on March 7-9, 2007 which evidently produced an agreement to continue discussions which apparently had been going on for quite some months. What is the present status?
3. In August 06, OEM stated it was working on a Joint Information Center. In March 07, OEM stated it had not yet found a location for the project. Why not?
4. In August 06, OEM responded regarding emergency plans and supplies for county employees. In March 07, OEM said this project was in process and that a manual on the subject was to be completed by May 07. Has this been done yet?
5. In its final report of 2006, a recommendation was made regarding assistance to animal owners in an emergency situation. The response thereto advised that the L A County Animal Care and Control Department was the lead agency in providing information on animal issues and was routinely involved as a member of emergency planning groups; that animal evacuation was a part of many emergency response and evacuation plans. The Committee's follow up inquiry in February 07, asked whether there existed any documented standard operating procedure dealing with this subject. In March 07, OEM responded that there was currently no documented SOP regarding animal response and rescue but that a plan was being currently developed. How long is this expected to take, bearing in mind that after Katrina some Federal legislation dealt with this subject.
6. In August 06, OEM stated it was "currently" negotiating a contract with UCLA to develop a registration and informational web site for CERT volunteers. In March 07, OEM responded that a UCLA contract had been signed and completed but that an amendment thereto was pending. When will this be finalized?
7. With regard to the recommendation and response concerning the utilization of Ham operators, in August 06, OEM advised that the CAO and the Sheriff were active participants on a steering committee and every effort would be

made to develop a county wide solution to utilize these communication asset
In response to the Committee's follow up inquiries as to any develop over th
past year which encourages Ham operators to become involved with the
emergency communications process, in March 07, OEM covered equipment
upgrades but failed to respond to the inquiry concerning the incentives offer
to Ham operators and what their general response has been to the call to
become part of disaster response operations. Concerning the itemization of
upgraded equipment, the Committee would like to know whether the
equipment items listed are currently operational.

Show Me The Money

Emergency Rooms and Clinics, Who Pays?

Emergency Rooms Committee

Stuart L. Chason, Chair

Connie Leyba
Hannah Margolis
Marlene Markheim
Ung Yol Yu

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

SHOW ME THE MONEY!
EMERGENCY ROOMS AND CLINICS
WHO PAYS?

EXECUTIVE SUMMARY

The purpose of this investigation is to find out how emergency rooms and clinics in the County health system defray the cost of services. Our methodology included study of reference materials and interviews with executive personnel at the Los Angeles County Department of Health Services. Health care issues are among the most difficult issues to resolve with ever increasing costs, doctor and nurse shortages, and the financial burden of providing health services to the uninsured and underinsured.

Los Angeles County Department of Health Services has an operating budget of over three billion dollars. Revenue is received for two thirds of that budget. Approximately 45% of this revenue is provided by Medi-Cal, 3% to 5% by insurance, and 3% to 5% by Medicare. The budget receives operating subsidy from various funds including the Tobacco Settlement and Measure B; but it requires over three hundred and eighty million dollars from the general fund. Our preliminary investigation revealed that the County Department does request fees for service and has systems in place to collect.

This financial crisis has caused closures of both private and public institutions in Los Angeles County. There have been 25 hospital closures, including 13 emergency rooms since 1996. The Emergency Medical Treatment and Active Labor Act (EMTALA) is susceptible to misuse by millions of uninsured and underinsured individuals. This Federally unfunded mandate imposes stiff fines and penalties if its regulations are not followed. These regulations mandate treatment to anyone requesting care in an emergency room regardless of the ability to pay or whether the medical condition is appropriate for treatment in an emergency room.

One way these issues may be resolved is the creation of neighborhood community clinics. Los Angeles County is in the process of creating such a clinic network, and is in the process of upgrading an electronic record keeping system. This upgrade would allow information to be transmitted between hospitals and clinics regarding medical conditions and method of payment.

HISTORY

Health care issues have come to the forefront as one of the Country's most difficult problems. Healthcare costs continue to spiral upward uncontrolled. There is a continuing shortage of doctors and nurses, and we are overwhelmed by the burden of the uninsured and underinsured. The crisis caused by the closure of ERs has added to the financial crisis facing the citizens of Los Angeles County. Since 1996, 25 hospitals including 13 emergency rooms closed in L. A. County. (California Hospital Association 10/5/06) A map of closed facilities in Los Angeles County is attached as exhibit 1.

The closure of these emergency rooms negatively impacts the health of our citizens by requiring them to travel greater distances for care or being forced to wait extended periods of time at the facilities that have remained open.

The closures are partially the result of the way emergency rooms are used by the indigent. It is a two-fold problem. There are those presenting themselves for appropriate emergency care who are subsequently admitted into a costly acute care bed. The other end of the spectrum is the huge number of individuals utilizing the ER for urgent care /clinical needs, without paying for services. In addition, patients of small clinics are referred to emergency rooms for X-rays or specialized evaluations.

The cost of treating an individual in the ER is 6 times the cost of treatment in a physician's office, and costs the County an estimated uncompensated $1.6 billion annually. The average emergency room visit in a Los Angeles County Hospital is estimated to cost $1200. The cost of an inpatient day is around $2400. ("The ER Crisis," California Medical Association, 7/2004")

The Emergency Medical Treatment and Active Labor Act ("EMTALA") was legislated in 1986 by Congress, and is susceptible to misuse by millions of indigents and uninsured individuals by removing the attending medical professionals ability to redirect them to clinical care for less serious issues. Care in the emergency room must be provided prior to determining ability to pay.

This problem is so pervasive and severe, even passage of Measure B in 2003(providing County funding with matching Federal funding) has not solved the problem since additional closures have occurred. We continue on a collision course until changes in policies and procedures are adopted and we regain the right to move patients into an appropriate level of care matching their illness/injury.

PURPOSE

The committee was formed because of concern over the un-reimbursed cost of providing care in County medical facilities. Our purpose is to find out how emergency rooms and clinics defray the costs of medical services rendered. Improvements in this area would benefit taxpayers.

Our questions for Department of Health Services were:

1. Are patients asked if they have any coverage when they receive care?
2. Are patients sent a bill for services rendered?
3. If so, is there follow-up on outstanding bills?
4. If not, is there an effort to encourage patients to pay for at least a fraction of the services?

Our preliminary investigation revealed that the Department not only does all of the above, but has a system in place to provide assistance to people in order to obtain Medi-Cal coverage. The Department furthermore utilizes the services of collection agencies which are paid on the basis of the amounts collected.

METHODOLOGY

Our investigation included study of published reference materials, as well as interviews with executive personnel at the County Department of Health Services.

FINDINGS

Medical Insurance in General (Third Party Payers)

The cost of medical care is too prohibitive for most people. Some may have medical insurance through work. Some pay for insurance, but for many the premiums are too costly. The United States Government in the 1960s enacted the programs to pay for Medicare,(health care for the elderly) and Medicaid,(health care for the medically "indigent"). The latter requires state matching funds up to 50% depending on the wealth of the state. In California, Medicaid is known as Medi-Cal. Many people receive both Medicare and Medi-Cal. These and other combinations of health insurance frequently complement each other and fill in the gaps of coverage lacking in the other plan.

1. Medi-Cal

Medi-Cal coverage is automatic for low income people receiving supplemental Social Security Income "SSI" (Currently $836 per month maximum for an individual and no more then $2000 total assets, excluding home, car for transportation, and personal belongings, and a small allowance for incidentals). One can also receive Medi-Cal through the Aged and Disabled Federal Poverty Level Program. Again, income must be low (currently $1047 maximum for an individual and no more than $2000 in assets). Some people with higher incomes may qualify for Medi-Cal with a share of cost if their medical costs leave them with less than $600 for an individual with assets of no more than $2000.Some have other forms of insurance or a share of cost, which are paid before Medi-Cal. Some undocumented aliens may have restricted Medi-Cal benefits as specified on their Medi-Cal card and these usually include only emergency care.

Medi-Cal partially finances Healthy Families, a specialized program. This program provides health coverage for children in families without insurance. Participants pay $4-9 per child up to a maximum of $27 per family. There is a $5 co-pay for visit, prescription medication, and emergency room services.

2. Medicare

Medicare has four parts. Part A covers hospitalization for acute conditions and skilled nursing care, not for chronic conditions. Part B covers outpatient medical care of all types. Part C (Medicare Advantage) allows a provider organization to provide all needs at a reduced cost. The member must have both Medicare Part A and B. Prescription drugs have recently been added to Medicare coverage under Part D. People who are 65 or older (or their spouses) have worked 10 years (40 quarters) in Medicare covered employment, and are citizens or legal residents of the United States will qualify for Medicare. A person may also qualify under certain conditions if they have worked fewer than 40 quarters. People who are younger than 65 and are disabled will

qualify if they have received Social Security Disability Insurance or Railroad Retirement disability payments for 24 months.

3. Private Insurance

Premiums are expensive unless paid all or part by the employer. Many companies offer medical insurance. It may require considerable research on the part of the buyer since there is a great disparity in the coverage offered.

Outpatient Prepayment Plans for Los Angeles County Facilities

This plan is available to patients who have little money and are Los Angeles County residents. These patients are approved after financial screening and once this status is granted, the following pre-payment charges are in effect:

1. Health Centers (except Urgent Care Center visits)	$ 50.
2. Prenatal services for the first seven visits remaining prenatal visits at no charge.	$ 50.
3. County Hospital Outpatient Clinics, except Emergency Room visits	$ 60.
4. Multi-Service Ambulatory Care Center	$ 60.
5. Comprehensive Health Center Urgent Care Center	$ 65.
6. County Hospital Emergency Rooms	$100.
7. Outpatient Surgery Clinics	$300.

Problems with Emergency Room Payments

Los Angeles County has four hospitals with emergency departments. All patients entering these departments are medically screened and provided with the appropriate medical stabilizing treatment before any inquiry is made about their ability to pay. Individuals with immediate life threatening symptoms such as bleeding or an obstruction in the airway are classified as category 1 and are seen immediately by medical staff.

The method of providing medical treatment first and then inquiring about the patients ability to pay is governed by legislation in the "Emergency Medical Treatment and Active Labor Act"(EMTALA). This Law was enacted by Congress in 1986 and final regulations were issued in1994. EMTALA is a federally unfunded mandate and imposes stiff fines and penalties on a hospital or physician not following its regulations.

Los Angeles County is in the process of updating electronic records. In the past six months the Harbor UCLA complex has upgraded its system making it possible to obtain information from the associated clinics. This upgrade provides information about previous treatments and methods of payment for patients, and would make it possible for immediate billing. The other three hospitals have yet to complete this process.

Financial Considerations in Clinics

With the passage of EMTALA in 1986, emergency rooms turned into de-facto clinics; treating a wide variety of ailments, many not actually emergencies. This practice of treating many uninsured, nonpaying patients resulted in creating a fiscal burden on emergency rooms that forced many of them to close.

One answer to the problem was the creation by the County of comprehensive health centers and clinics, whose mission is to provide a wide range of services in a culturally sensitive manner. These clinics provide a wide range of health services. These health centers and clinics are required by County policy to charge for services rendered, and may ask patients about payment on entry.

Patients may apply for an Ability to Pay Plan ("ATP") for all or part of the medical or dental services provided. This process includes the filling out of a form and an interview to determine their share of payment primarily based on their income. They are evaluated for ATP at every admission and after 30 days if hospitalized. They are also evaluated every six months to confirm their continuing ATP coverage.

People with Medi-Cal (or Medi-Cal qualified), Medicare or other medical insurance may enroll in the Community Health Plan and will not incur additional charges.

If patients do not bring money with them, they are given an envelope with instructions to remit the amount owed within seven days. Other Counties have found that if a timely reminder is sent, more money may be recouped.

Patients are requested to provide the following to register:

Clinic card
Drivers license
Address verification
Medi-Cal or Medicare card (if applicable)
Telephone number
Birthdate

Follow-up to Unpaid Bills for Medical Services

1. County's Efforts

If the patients leave the medical facility without paying their agreed upon share, three reminder letters are sent by the County. If payment is still not forthcoming, three additional letters of collection are sent.

Payments owed by third parties (e.g. Medi-Cal) are collected. If necessary, appropriate arbitration is used to settle disputes. Pursuit of individual collection may reveal the possibility of third party liability such as workers compensation or other personal injury damages.

2. Contractor/Vendor Efforts

Health advocates, collection agencies, government agencies and law firms assist in the follow-up collection of delinquent funds. Collection agencies are paid only when funds are collected.

Financial Considerations

Los Angeles County Department of Health Services has an operating budget of over three billion dollars. Revenue is received for two thirds of that budget. Approximately 45% of this revenue is provided by Medi-Cal, 3% to 5% by insurance, and 3% to 5% by Medicare. The budget receives an operating subsidy from various funds including the Tobacco Settlement and Measure B, but it requires over three hundred and eighty million dollars from the County's general fund.

CONCLUSIONS

The Department of Health Services must be commended for its conscientious effort to collect all possible revenue. This function is primarily carried out by Health Services Administration, Revenue Services. Patients are asked about their coverage, are billed for services rendered and, if appropriate, services rendered can be prepaid. The Department also receives and utilizes special funds such as Measure B, and Tobacco Settlement funds. The Department encourages the use of clinics rather than ERs in an attempt to minimize un-reimbursed costs of health in the County.

RECOMMENDATIONS

To Department of Health Services and the Board of Supervisors:

1. Mandate the completion and upgrade of electronic records for emergency rooms.

2. Encourage changes in regulations and support the development of nonprofit private clinics and programs. Camino de Salud is a program where the patient is encouraged to visit a County or private clinic in his or her neighborhood.

3. Lobby for the modification of EMTALA regulations and funding because of the burden it places on the taxpayers of Los Angeles County.

4. Develop a system of associated urgent care clinics where patients can be directed, rather than utilizing emergency rooms.

Triple Jeopardy

Abandoned, Neglected, and Abused Children of Los Angeles County

Group Homes Committee

Linda F. Winfield, Chair
Joe Contreras, CoChair

Nola Burnett
Connie Layba
Otha Scott

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

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TRIPLE JEOPARDY: ABANDONED, NEGLECTED, AND ABUSED CHILDREN OF LOS ANGELES COUNTY

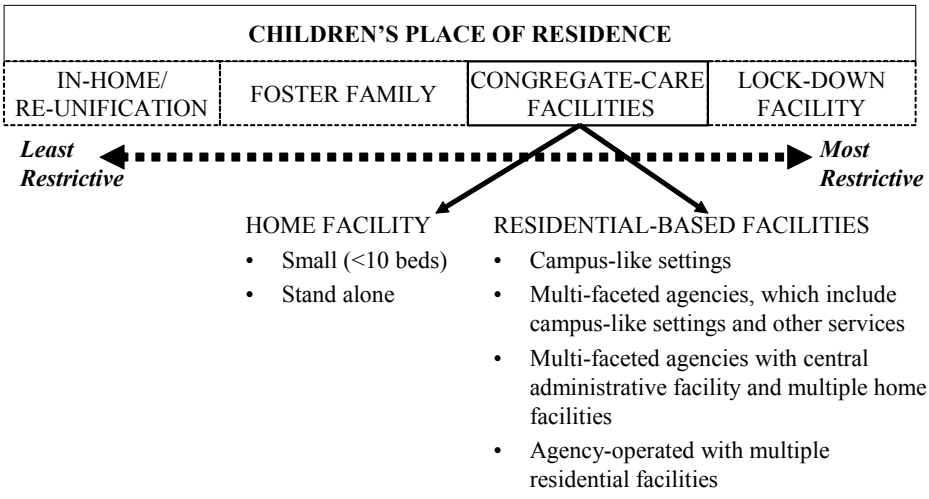
PREFACE

This investigation by the 2006-2007 Civil Grand Jury (CGJ) revealed that a review of group homes was not a simple matter. The term "group home," though commonly used, has many different interpretations due to the range of services and quality of care provided, from minimal to comprehensive. The CGJ has redefined the term "group homes" and refers to them as "congregate-care facilities" (see diagram below).

Moreover, the authorities concerned with the care of children who are the County's wards and dependents differ dramatically in their judgments of these congregate-care facilities. The range of quality of care provided varies from truly excellent to abysmal. This situation is compounded by the fact that State funding levels for congregate-care facilities have not changed in many years. This affects the ability to hire qualified staff, establish reasonable staffing ratios, provide aftercare services, and deliver other programs necessary to provide quality services. Beyond the complex evaluation of these facilities lie the uneven, conflicting, and inconsistent efforts made by the Department of Children & Family Services (DCFS) and Probation Department. These Departments manage their assigned children's cases, including their initial placement, monitoring and tracking them over time, and developing their exit plans (e.g., end-result reporting and outcomes).

The State licenses congregate-care facilities. It has established a Rate Classification System (RCL) assigning the level of "residential-based services" provided in the facility. It is the County's responsibility, however, to guarantee the quality of care provided. This report includes information from on-site visits made by the CGJ to a selected sampling of congregate-care facilities. It explores the changes that DCFS and Probation should be making to improve the quality of care provided and asks the questions:

Which of these facilities are <u>inappropriate</u> for placement?
Which of these facilities are <u>underutilized</u>?



I – EXECUTIVE SUMMARY

Jackie's Story

Jackie, a thirteen year old girl was removed from her heroin-addicted birth mother at age 4 after she and her brother were sexually abused by her mother's boyfriend and slapped and beaten by her mother as a means of discipline. In the first foster home, she suffered more abuse. In the second foster home over a nine year period, she became defiant, suspended from school for fighting, ran away and ended up in a temporary homeless shelter on skid row. In the current residential based facility, she has been found to be intelligent although guarded, has low self esteem, and displays inappropriate affect, unrealistic fear, excessive guilt, anger, mood swings, and depression. She has been described as delusional, suicidal with bizarre thinking, paranoid, and depressed, and self-destructive. She was not on psychotropic medication and was listed as "non compliant". One medical examination indicated that she was "mentally retarded", yet another psychological evaluation indicated "cognitive ability - high average". Although she has a 2.94 grade average (in 9th grade) and wants to be a nurse, she has an inability to focus on her studies. She had formed an attachment to her former foster mother where her brother resides, and reunification is being pursued.

CGJ 2006-2007 encountered this case during a site visit. As a result of this case, complaints to the Ombudsman, the Auditor-Controller's reports, and the findings of previous CGJ reports, the 2006-2007 CGJ decided to investigate the use of congregate care for children in the child welfare and juvenile justice systems. Much of the previous literature refers to "group homes" as an all encompassing category, which does not reflect the breadth of congregate-care facilities and services rendered. The effects of congregate-care settings are confounded with type of facility, quality of facility and staff, staffing levels, severity of problems of children placed, prior placements, services rendered, and other variables.

In the County of Los Angeles, children in the juvenile justice system are called wards assigned to the Probation Department; they can be placed in lock-up in camps or Juvenile Hall or in congregate-care settings, typically group homes. Only a few are assigned to live at home or with relatives. A variety of options is available to children, called dependents, in the child welfare system under the DCFS. Dependents are generally placed at home, with relatives, with foster families, or at congregate-care facilities. Probation views congregate-care facilities as less restrictive and a preferred option compared to the two lock-up options. DCFS views congregate-care facilities as the least preferred option for placement of their children.

DCFS and Probation are currently using 238 group homes that are licensed by the State of California. The group homes range in size from 5 to 143 beds. The State license determines the monthly fees paid based on the level and type of services provided. The fees range from $2,589 to $6,371 per child per month. DCFS and Probation have approximately 1,500 dependents and 1,300 wards respectively placed in group homes, representing 4% and 23 % of the 38,000 and 5,700 children in the two systems.

Within the broad category of congregate-care facilities, the CGJ has developed its own classifications:

Residential-based facilities

- Campus-like settings with a range of services – treatment centers, schools, and transitional programs
- Multi-faceted agencies, which include campus-like settings and foster family services, adoption services, and residential facilities
- Multi-faceted agencies with central administrative facility and multiple group home facilities
- Agency-operated with multiple residential facilities
- Stand-alone, small group facilities (<10 beds)

The trend in the literature and emerging best practices indicate the reliance on group homes should be curtailed. The implication is that group homes are inferior to placement in a foster home because of a lack of a parental authority figure on a 24/7 basis. Dependents and wards need continuity, unconditional love, emotional support, and boundaries needed by children to thrive. The group home environment makes the transition more complicated when a child is reunified with his/her family.

In contrast, within the CGJ's classifications, the CGJ found differences in practice:

- With appropriate placement, children needing RCL-6 through RCL-10 residential-based services can do well in stand-alone, small group facilities.
- A number of residential-based facilities have remarkable success with the children in their care. Some had particularly impressive transition programs that provide job and housing support when a child emancipates or ages out of the system. They help them to become young, responsible adults with a solid foothold in the community.

Because congregate-care facilities are only a component of a larger system of care for dependents and wards, the investigation's conclusions go beyond group homes and address systems, organizational, and program issues in the Departments. Specifically:

- New prevention programs with specific reduction goals are required to staunch the flow of children entering the systems.
- The Departments, in addition to evaluating the intermediate effectiveness of specific programs, need to follow up on children after they leave the systems and collect longitudinal data to measure the real impact of the systems on a child's life trajectory.
- The information systems need to be improved, automated, and integrated to ensure that accessible and comprehensive information is maintained on each child.
- Team decision-making, involving all the caregivers involved with the child, and where confidential information can be shared, should be the norm to ensure optimal decisions are made for the child.
- Stability and continuity is important for a child's well-being. Both systems need to minimize the turnover of Children Social Workers (CSWs); DCFS must reduce the number of placements of their dependents. The Departments should set goals of one case worker throughout the child's stay in the system and one placement per child.
- An organizational review is needed to address the current staffing levels in both Departments. New and more realistic case ratios are required and should be related to the complexity of

the cases assigned. A higher-level position of case manager should be considered for the more complex cases. The development of new systems, technology, and equipment that provide better information in real time should be part of the review.

To support the stability goals, a new comprehensive placement assessment protocol is needed to ensure that each child is: a) assigned a CSW or Deputy Probation Officer (DPO), who are trained caseworkers with the appropriate skills, and b) then placed appropriately.

More foster families need to be recruited and new classes of highly trained foster family caregivers are required to reduce the number of children inappropriately placed in congregate-care facilities.

Children should not be placed in congregate-care facilities if the facilities are not able to provide high quality, comprehensive services.

Improved educational strategies are needed to help many of the children achieve at or above their grade levels and improve their life trajectory.

To avoid potentially negative peer influences, DCFS dependents and Probation wards should never be assigned to the same group facility.

Some congregate-care facilities raise significant funds in the community to support and enrich their programs and services but overall most are under-funded, given the services they are required to provide.

Wraparound Services – that provide supports to families to prevent children from being removed and supports after they are returned or permanently placed elsewhere – are valuable but the efficacy of delegating this to a third-party is questionable because of fragmentation and coordination problems.

There is little contact and sharing of information between congregate-care facilities and other care providers or across County departments. Annual forums for sharing successful programs, best practices, and strategies could lead to improved system-wide performance.

Children entering both systems are still in their formative years. Many are damaged and vulnerable. Program and system improvements are needed to help more of them attain better life trajectories than they face when they enter the child welfare or juvenile justice systems.

The current goals are excellent: a) achievement of permanent placement, including reuniting with parents as fast as possible, and b) placement in the least restrictive accommodation. These goals need to be tempered by practical considerations and the needs of the child. An early removal that negatively disrupts the child's schooling for instance should be avoided.

Despite the current views and best practice research, there will likely always be a subset of children who cannot or should not be placed permanently with their family or relatives. These children thrive better in a comprehensive structured program offered by some of the larger congregate-care facilities that provide care in campus settings. Wards who have been entangled in gangs and children who have substance abuse problems are two examples.

This CGJ investigation makes recommendations to: a) ensure the placement of children in congregate-care facilities is appropriate; b) improve their care and potential life trajectories; and c) maintain and improve the support of those congregate-care facilities who are currently successful with the children they are assigned.

II – HISTORY AND BACKGROUND

NATIONAL TRENDS IN RESIDENTIAL CARE

The Child Welfare League of America (CWLA) defines Residential-Based Services (RBS) as:

> *Resident group care encompasses a broad array of services for children with pronounced special needs. Residential services are highly flexible and provide for varying lengths of stay, based on the client's needs. Lengths of stay may range from a short respite due to tense family situations, to long-term therapy for problems such as drug or alcohol addiction. Although long-term stays in family-like community-based group homes best serve some children's individual needs, residential group care is usually a temporary placement. Many children in residential care have emotional or physical conditions that require intensive, on-site therapy[;] others receive services from day treatment programs in their communities. Residential care programs are highly flexible and are designed to meet each child's individual needs.*[80]

RBS can involve a broad array of residential options for children living out-of-home, including half-way homes, campus-based homes, emergency shelters, self-contained settings, and staff-secured settings.[81] Child welfare systems attempt to work with children and families in the least restrictive environment (e.g., biological, kinship, or foster family home). When such environments are unavailable or insufficient in meeting the needs of individuals, child welfare systems place dependents into more restrictive settings.

Current laws and policies require that children be placed in the least restrictive setting to meet their needs. Relatives or kin are given priority in placement decisions wherever possible. Other family settings include family foster care. Placement priorities are to keep the child:

1) In the home if they are not endangered
2) With relatives
3) In a foster family
4) In congregate-care facilities

In some cases, children entering out-of-home care are temporarily placed into an emergency foster care setting, which may be either a family, or a group setting.

Of the 500,000 dependents in foster care in the United States, approximately 20% live in a group home or other residential institution.[82] Within the social service continuum of care, congregate-care facilities are less restrictive than in-patient psychiatric clinics and juvenile detention centers, but more restrictive than foster family care.[83]

In all instances, the continuum is building blocks toward reunification with one's family if possible.

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[80] Child Welfare League of America (CWLA): Child Welfare, Residential Group: www.cwla.org/programs/groupcare/groupcareaboutpage.htm
[81] Curtis, Alexander, & Lunghofer, 2001, CWLA, 2005.
[82] Administration for Children and Families, 2003; Jonson-Reid & Barth, 2000a, 2000b.
[83] Handwerk, Friman, Mott, & Stairs, 1998.

Group facilities are used in a variety of social service settings, including child welfare, mental health, and juvenile justice. Group facilities tend to be:

Smaller than other residential facilities, consisting of a medium-size homes capable of housing between 8 and 12 adolescents in a community-based setting

Staff secured as opposed to a locked facility

Staffed with employees who work 24 hours/day

Reliant on the public schools to educate their assigned children

Group homes are one of the most expensive placements options for child welfare systems, given the staffing ratios. In 2000, 43% of all substitute care dollars in the State of California were associated with group home placements.[84] Because the majority of children never enter a congregate-care setting, and the lengths of stay within these settings is significantly shorter than traditional foster family placements, the high costs and overall proportion of the budget allocated to such placements requires that agencies assess the viability of such placements.

Children in group homes stay an average of 10 to 20 months.[85] Children from California group homes and foster homes have the lowest median lengths of stay (12 and 13 months, respectively), in comparison with California treatment foster care and kinship care, which have the highest medians (25 and 20 months, respectively).[86]

Characteristics of Children Served In Congregate-Care Settings

Across the nation, approximately 20% of child welfare placement cases enter congregate-care settings because some dependents are better suited to enter such facilities or no other placement options are available. As compared to traditional or specialized foster care homes, children living in congregate-care settings are more likely to be: older, male, minority, experiencing a range of socio-emotional and behavioral problems, and previously involved with the juvenile justice system.[87]

Congregate-Care Placements

A healthy debate exists regarding the effectiveness of congregate-care settings. Central to this debate is the issue of peer groups and the socialization of adolescents living in congregate-care settings. Those supportive of congregate-care placements argue that youth can be influenced by positive peer behaviors. Those advocating the termination of such placements argue that congregate-care institutions generally serve high-risk children in close confines, thus, increasing the chances for reinforcing negative attitudes, values, and beliefs. A chart summarizing studies of the positive and negative effects of residential group settings is on the following page.

[84] CA Department of Social Services Research and Development Division (RADD), 2001.
[85] CA RADD, 2001.
[86] Chamberlain (1998).
[87] Berrick, Courtney, & Barth, 1993; Curtis et al., 2001; Knapp, Baines, Bryson, & Lewis, 1987; Mech, Ludy-Dobson, & Hulseman, 1994.

Residential Group Care Settings	
Positive Effects	**Negative Effects**
A number of studies have identified positive outcomes: • **A study of children diagnosed with conduct disorder in residential care – caregivers' concerns decreased between admission and discharge and six months, one year, and two years after post-discharge.[88]** • **A retrospective study of 200 children served in group homes in the Midwest – as adults, 70% had completed high school, 27% had some college or vocational training, and 14% received public assistance.[89]** • **A Canadian study of 40 children in resident care – the majority of the children were functioning at severely impaired levels at admissions, moderately impaired at discharge, and normal one- to three-years post-discharge.[90]** **A specific clinical model – positive peer culture (PPC) – for youth in the juvenile corrections system and housed in residential settings found that:[91]** • **Juveniles are capable of establishing and reinforcing socially acceptable behaviors.** • **Juveniles not only take responsibility for their behaviors, but for the behaviors of the entire group.** • **Decisions regarding the progression of treatment (e.g., recreational rewards, level movements, family visitation) are made collectively.** • **As a group, juveniles learn to trust, respect, and take responsibility for the actions of others; norms can be established that not only extinguish anti-social conduct, but more importantly**	• **In a well-publicized study,[92] peer group interventions might increase adolescent behavior problems and negative life outcomes in adulthood.** • **On the basis of two experimental studies, the high-risk youth, compared with low-risk youth, were particularly vulnerable to peer aggregations.** • **In part, the potential problems associated with group home placements stem from the ties that are often severed between group home youth and other more positive role models (peers and adults).** • **Group homes often cut juveniles off from their non-delinquent and pro-social peers and keep them with youth who often are delinquent or have emotional and behavioral problems (including conduct disorders and Attention-Deficit/Hyperactivity Disorder (ADHD) in a congregated setting for 24 hours a day.[93]** • **Group care is not safe, does not promote healthy development, is not stable, exceeds the cost of other types of care, and is not cost efficient.[94]** • **Children from group care report seeing family members less than children in kinship care, are less likely to be reunified, and are more likely to return to group care, especially children aged 6 to 12.[95]** • **As compared with children in specialized foster care, adolescents living in group care are more likely to suffer from extreme behavioral and social adjustment difficulties, including sexual acting out, developmental disabilities, suicidal ideation and attempts, self-induced injuries,**

[88] Day, Pal, & Goldberg, 1994, cited in CWLA Position Statement on Resident Services, pp. 1-2.
[89] Alexander & Huberty, 1993, cited in CWLA Position Statement on Resident Services, pp. 2.
[90] Blackman, Eustace, & Chowdhury, 1991, cited in CWLA Position Statement on Resident Services, p. 1.
[91] Vorrath and Brentro, 1985.
[92] Dishion et al., 1999.
[93] Osgood & Briddell, 2006.
[94] Barth, 2002.
[95] Barth, 2002; Wulczyn, Hislop, & Goerge, 2001.

Residential Group Care Settings	
Positive Effects	Negative Effects
reinforce pro-social attitudes, beliefs, and behaviors.	**eating disorders, substance abuse, and aggression.[96]** • **Children in group care have fewer opportunities to practice real life tasks.[97]** • **Children in group homes also have more academic problems. Compared with youth in family foster care, dependents in group homes received mostly C or below grades in school, have truancy problems, enroll in remedial classes, and attain lower levels of education.[98]**

Considerable evidence suggests that: a) group care programs increase the likelihood of negative outcomes, and b) detaining children in congregate residential settings may exacerbate delinquency through exposure to deviant peers.

Mitigating Factors. The effects of placements may vary by individual, that is, an interaction may exist between congregate-care placements and the characteristics of the individual. The negative effects of living in congregate care is likely to be a function of:

Self-identity and influence of other factors (e.g., the developmental status of the child, the interactions of the other children who live there, and the context in which the intervention is provided). Children who are firmly grounded in their identity may be more likely to resist peer temptation.

Defiant influences and tendencies (e.g., level of deviance a peer has upon entrance into a facility, the number of deviant peers present, and the length and amount of deviant peer exposure). A child who is moderately deviant may be more susceptible to become involved in delinquent friendships.

Educational problems may be more prevalent for those in group care because of children's limited opportunity for individual development and involvement in extra-curricular activities, which help to promote well-being and self-confidence. Group home facilities may also impede learning and studying because of resource shortages (e.g., lack of adequate study areas and staff to help with homework).

Unfortunately little is known about which youth are most likely to succeed in congregate-care programs. To date, no evaluations exist that focus specifically on PPC models within the context of the child welfare system. Few studies have looked at factors which contribute to resilience among young people in congregate care facilities. Resilience is defined as an individual's ability to cope in a successful manner in adverse circumstances. This skill is not a psychological trait, rather it is a set of protective factors and risks that modify the individual's response to the

[96] Berrick et al., 1993.
[97] Barth, 2002.
[98] Berrick et al., 1993; Festinger, 1983; Knapp et al., 1987; Mech et al., 1994.

situation and occur at critical transition points[99]. Resilient children in out-of- home care had: 1) high quality relationships with caregivers and friends, 2) received consistent encouragement and support to foster self esteem, and 3) experienced interventions which strengthened social abilities and social connections[100] . Emancipated foster youth who were successful in attending a four-year college experienced stable school attendance, a challenging high school curriculum, considerable social support, and participation in prosocial organizations and groups. However, these youth still experienced financial difficulties, psychological distress, and a lack of health insurance and access to health services[101].

Appendix A lists commonly used acronyms and Appendix E contains the References for this document.

PROFILE OF RESIDENTIAL CARE IN LOS ANGELES COUNTY

Two agencies – the Department of Children and Family Services (DCFS) and the Probation Department in Los Angeles County –were the focus of this CGJ investigation. The front-line, field workers are CSWs in DCFS and DPOs in Probation. The terminology used in referring to the children is:

Dependent for a child placed in the child welfare system under DCFS's care

Ward for a child under the juvenile justice system of Probation

Children if referring to both dependents and wards

The systems have many stakeholders, service providers, and agencies involved. Nearly 60,000 children enter and exit the child welfare system and juvenile justice systems each year. The County contracts with private entities to provide foster family and congregate-care settings. Multiple agencies and ancillary services protect the children's interests:

- DCFS and Probation – develop a case plan, conduct monthly visits, and provide quarterly updates to the courts on the child's status, conduct routine on-site inspections
- Children's Law Center – has court-appointed lawyers for the children
- The Children's Alliance – has court-appointed lawyers for the children and implements recommendations on improving the health of foster children
- CASAs – are volunteers who are court-appointed special advocates
- Auditor-Controller – inspect facilities, conduct program compliance reviews, and interview children
- Ombudsman – an advocate and problem-solver who is on-call for the children

[99] Linda F. Winfield, 1991 "Resilience, schooling and development among African American Youth: A Conceptual Framework". Special Issue: Education and Urban Society, CA.: Corwin Press, Sage Publications, 5-14.
[100] Louise Legault, Michele Anawati and Robert Flynn 2006 "Factors favoring psychological resilience among fostered young people", Children and Youth Services Review, 28, 1024-1038.
[101] Joan M. Merdinger, Alice M. Hines, Kathy Lemon Osterling and Paige Wyatt 2005. Pathways to college for former foster youth: Understanding factors that contribute to educational success", Child Welfare, Vol. LXXIV, #6, November/December, 867-896.

The Education Coordinating Council – is a non-profit group that brings together stakeholders (i.e., the courts, DCFS, Probation, school districts) with the goal of raising the achievement levels of foster children in the County

The Association of Community Health Service Agencies (ACHSA) – represents many of the providers and reviews the overall care of children under their jurisdiction

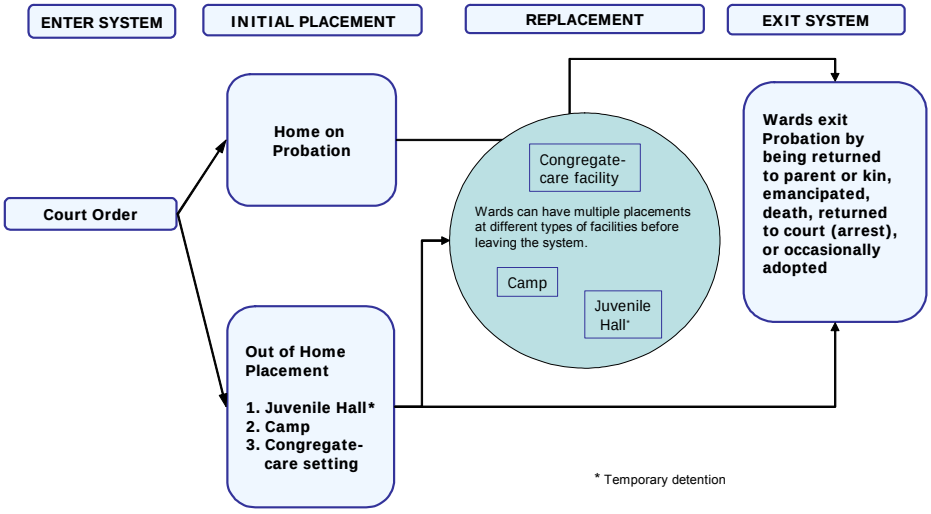
Various supportive services (i.e., mental health, tutoring, and social work) are provided for the children.

Entry-Exit Process for Wards

The flowchart in Exhibit I displays how wards enter and exit the juvenile justice system, starting with the court order and initial placement. Wards' confinement is according to the terms set by the court; the children are a ward of the County during that period. They require similar placement and services, albeit with certain court restraints while under the supervision of Probation and until they are returned home. In April 2007, 5,215 wards entered the juvenile justice system and were placed in out-of-home environments: camps (39%) and group homes (26%). The others were temporarily assigned to Juvenile Hall (33%) until their placement decisions were made. Wards typically have only one placement while in the system.

EXHIBIT I

Entry-Exit from the Probation Juvenile Justice System

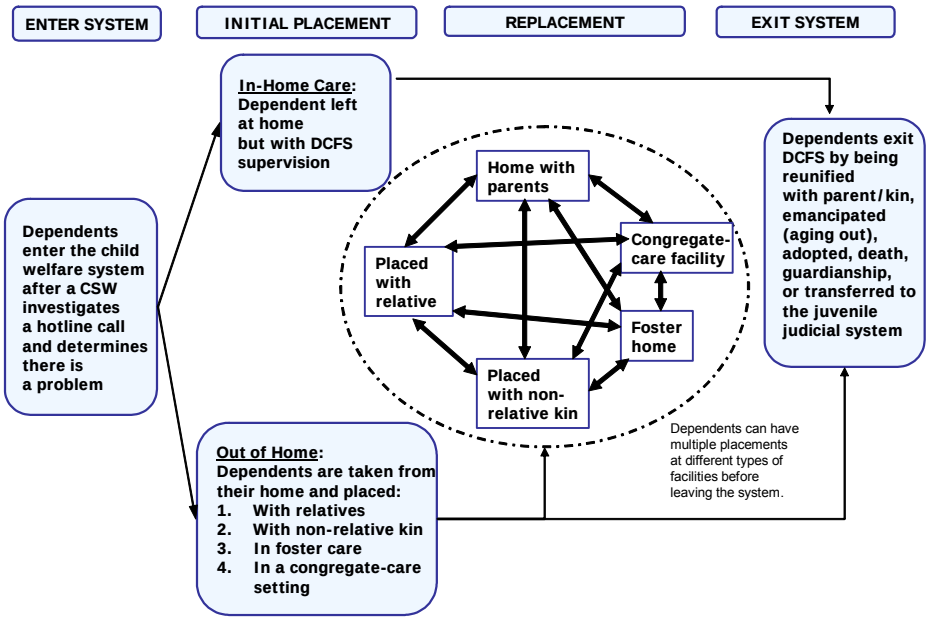


Entry-Exit Process for Dependents

The Exhibit II flowchart displays how dependents enter and exit the child welfare system, a much more complex process. Dependents enter the child welfare system after a CSW investigates a referral and determines there is a problem. DCFS pays for the support of the dependents, additional services required, and individual educational programs.

EXHIBIT II

Entry-Exit from the DCFS Child Welfare System



The courts and DCFS's CSWs determine the dependents' needs and placements. As shown in Table 1, most are assigned to a relative's home (45.7%) or a Foster Family Agency (FAA) certified home (25.4%).

Table 1: Dependents' Placements

Type of Placement	#	%
Relative Home	10,868	45.7
FFA Certified Home	6,029	25.4
Guardian Home	3,301	13.9
Foster Family Home	1,998	8.4
Group Home	1,559	6.6
Total	23,755	100.0

Source: UC Berkeley estimates for DCFS

Dependents return to court every six months; the courts reassess the jurisdiction and may return the children home, if appropriate. After the initial placement, a dependent may have multiple new placements, called replacements, while in the child welfare system. The long-term goal of DCFS is reunification with the family or another form of legal permanency, either adoption or legal guardianship.

Children Served

In March 2007, Probation had 1,378 wards placed in congregate-care settings. DCFS had a total of 37,979 dependents receiving DCFS services. Most dependents were in permanent placement, such as adoption, long-term foster care, or guardianship, or at home with parents under DCFS supervision, as shown in Table 2.

Table 2: Caseloads for Dependents In-Home and Out-of-Home Services
March 2007

Caseload	Number
Permanent Placement (adoption, long-term foster care, or guardianship)	14,691
Family Maintenance (dependents at home with parents under DCFS supervision)	10,831
Family Reunification (dependents in DCFS out-of-home care planning to reunify with their parents once the home situation has improved)	9,729
Adoption Services Cases (adoption in process)	1,802
Emergency Response, including open cases	926
Total Dependents Receiving Child Welfare Services	37,979

Most of the dependents referred to DCFS on an emergency basis (approximately 15,000 per month) enter the system after a CSW visits a home to investigate an allegation.

Dependents are evenly dispersed between male (49.7%) and female (50.3%), are 5-13 years old, and are mostly Hispanic (50.9%) or African-American (31.7%), as displayed in Table 3. In contrast, wards are mostly male (81.3%) and 15-17 years old. Similar to the dependents, they are mostly Hispanic (58.3%) or African-American (31.3%). The proportion of Hispanics is not too dissimilar from that found in the general population.

Table 3: Profiles of Dependents and Wards
March 2007

Child Characteristics	Dependents		Wards	
	#	%	#	%
Age				
Birth-2 years	6,460	17.0	-	**-**
3-4 Years	3,702	9.7	-	**-**
5-9 Years	8,872	23.4	-	**-**
10-13 Years	7,769	20.5	73	**5.3**
14-15 Years	4,670	12.3	431	**31.2**
16-17 Years	4,576	12.0	813	**59.0**
18 Years and Older	1,930	5.1	61	**4.5**
Age Total	***37,979***	***100.0***	***1,378***	*100.0*
Ethnicity				
Hispanic	19,347	50.9	804	**58.3**
African-American	12,039	31.7	432	**31.3**

Child Characteristics	Dependents		Wards	
	#	%	#	%
White	5,101	13.4	107	**7.8**
Asian/Pacific Islander	956	2.5	9	**0.7**
Filipino, American Indian/Alaskan Native, Other	536	1.5	26	**1.9**
Ethnicity Total	*37,979*	*100.0*	*1,378*	*100.0*

Group Home Classifications

Vendors must fulfill the administrative requirements to bid for Los Angeles County FFA and group home contracts. Once it has been determined that the minimum requirements have been satisfied, the County selects those vendors they deem to be qualified. The California Department of Social Services (CDSS) rates and licenses group homes via a Rate Classification Level (RCL), based on a 14-point system. The RCL determines the number of weighted staff hours per child per month for providing social work activities and mental health treatment services. In turn, the County of Los Angeles contracts with these State-licensed facilities. Most children receive RCL-10 through RCL-12 services. The RCL pay schedule is:

RCL	Monthly payments per child
14	$6,371
13	$5,994
12	$5,613
11	$5,234
10	$4,858
9	$4,479
8	$4,102
7	$3,723
6	$3,344
5	$2,966
4	$2,589

Los Angeles County 2002-2005 Trends

To gain an understanding of trends, this CGJ investigation did a statistical review of the child welfare records of all dependents (n=91,860) involved[102] with DCFS between 2002 and 2005. The delinquency records originate with Probation and include all arrests (n=230,259) for all minors (n=82,376) in Los Angeles County between 2002 and 2005. On average, during the five-year period studied (2002-2005):

Ethnicity profile. 48% were male; most were minorities: 43% African-American, 40% Hispanic, 15% White, and 2% Asian. *Note: This ethnic profile differs from that of March 2007, where the majority of the dependents were Hispanic (51%).*

[102] Involvement with child welfare in Los Angeles County includes any open or ongoing case between 2002 and 2005.

Placement trends. Dependents were 8.8 years old at the time of their first placement. 71% had at least one placement in foster care, 53% had at least one placement in a relative's care. and 23% had at least one congregate-care placement.

Length of stay and instability trends. Dependents stayed in care a total of 46 months. 49% of the dependents (n=20,309) experienced at least three different placements. Approximately 9% of them experienced a change in placement due to running away, referred to as Away Without Leave (AWOL), and 7% experienced a change in placement due to child behavioral problems.

Delinquency trends. 2,106 (10.4%) of 20,309 adolescents in placement had at least one arrest subsequent to their first placement episode.

In this CGJ investigation, the County database had approximately 6,400 adolescents with at least one congregate-care placement between 2002 and 2005. In contrast, the County had approximately 47,000 adolescents in other placement settings during the same period.

Placement Patterns

Table 4 compares In-Home Care and Out-of-Home Care for DCFS dependents. Since 2004, the percent of dependents served in-home has decreased.

Table 4: Number of DCFS Cases Opened Out of Referrals by In-Home Care and Out-of-Home Care (Foster Care) (2004 Through 2006)

Placement	2004	%	2005	%	2006	%
In-Home Care	12,110	66.9	13,425	65.3	12,407	62.8
Out-of-Home Care (Foster Care)	5,981	33.1	7,132	34.7	7,346	37.2
Total	**18,091**	**100.0**	**20,557**	**100.0**	**19,753**	**100.0**

Notes:
1. The table contains dependents who had a case opening out of referrals.
2. Data source is CWS/CMS Datamart as of 4/16/2007.

Congregate-Care Facility Profile

In Los Angeles County, congregate-care facilities range from 5 to 143 dependents or wards. The larger facilities are residential-based facilities. Group facilities have an average of 5.9 dependents per facility. Non-group homes – such as foster family homes, small family homes, and FFA-certified homes – average just 2.1 dependents per home.[103] Approximately 56 group homes serve both dependents (n=355) and wards (n=680) in the same setting; numerous homes have children from other counties as well. More than 50% of DCFS dependents and 67% of Probation's wards are placed in RCL-12 homes.[104] Despite repeated requests, CGJ was unable to obtain the amount budgeted for congregate care facilities. One DCFS official estimated that $200 million + per year was spent on these facilities; however this amount was not verified.

[103] DCFS data, as of December 31, 2006.
[104] See DCFS RCL table in "Findings" section.

III – PURPOSE

Congregate-care placements are an essential service option along the continuum within child welfare and juvenile justice systems because they serve some of the more complicated and difficult to place cases. In this investigation, the CGJ observed profound differences in the types of facility options available. Most of the research clumps outcomes together under a broad heading of "group homes" and does not distinguish about how they vary in their scope and services rendered. Therefore, in the remaining sections of this report, CGJ distinguishes among congregate-care facilities as:

Residential-based facilities – offer a breadth of support services: staff with specialized expertise, specially designed programs, on-site school programs, transition planning and support, community involvement, supervised activities, transitional housing, and enhancement activities (e.g., art, music, outreach programs, cooking, summer camps, and field trips).

Campus-like settings with a range of services – treatment centers, schools, and transitional programs

Multi-faceted agencies, which include campus-like settings and foster family services, adoption services, and residential facilities

Multi-faceted agencies with central administrative facility and multiple home facilities

Agency-operated with multiple residential facilities

Stand-alone, small group facilities (<10 beds)

This CGJ investigation has attempted to understand the true nature of congregate-care facilities. Three questions related to such placements were statistically investigated:

Question 1: *How do children placed in congregate-care facilities compare with children placed in other out-of-home placement settings?*

Question 2: *Are children in congregate-care facilities at higher risk for delinquency?*

Question 3: *What is the relationship between congregate-care placement and permanency outcomes (e.g., family reunification, adoption, or guardianship – all measurements of permanence placement for the children)?*

This CGJ investigation also reviewed system-wide management issues and processes – communications, placement, staffing, and performance monitoring.

IV – INVESTIGATION

Our qualitative fact-finding involved:

Formal Entrance and Exit Conferences with senior DCFS and Probation officials

DCFS and Probation data collection of trends pertaining to dependents in the child welfare system and wards in the juvenile justice system

20 Interviews with County department management and representatives: DCFS, Probation, the Ombudsperson, County Counsel, the courts, and Auditor-Controller

2 focus groups with 10 CSWs in DCFS and 5 DPOs in Probation

5 interviews or meetings with involved stakeholders and non-profit agencies: Association of County Human Service Agencies (ACHSA), Children's Law Center, CHAMPS, Alliance for Children's Rights, and Education Coordinating Council (ECC)

15 site visits and interviews at congregate-care settings, representing a range of facilities: 6-bed, stand-alone group home facilities; agency-operated, multiple 6-bed group home facilities; multi-faceted agency operated with foster family services and 6-bed home facilities; and campus-based facilities with 6-beds, treatment centers, schools, FFAs, and transitional programs. The site visits entailed the completion of a "Site Visit Assessment" form, commenting on the facilities, the children, the staffing, programs offered, schooling, transitional plans and housing, supervised activities, community involvement, enhancement activities, and other comments. Appendix D lists the sites visited.

Literature reviews and research on best practices

Quantitative analysis of County administrative records for all DCFS dependents and Probation wards and their respective families between 2002 and 2005[105]

In support of this CGJ investigation's quantitative analysis, Appendix B describes in detail:

The DCFS Records analyzed, starting with child welfare records of all dependents (n=91,860) involved[106] with DCFS between 2002 and 2005

The Probation Records analyzed, including all arrests (n=230,259) for all minors (n=82,376) in Los Angeles County between 2002 and 2005

The statistical process required to merge and match these administrative records by common identifiers was extremely complex. Despite trends elsewhere, when the County data were tested specifically for potential subgroup differences, no significant race or gender interactions emerged, so these terms were removed from the final models. Appendices B and C describe in greater detail the statistical techniques and significance of the summarized trends (2002-2005).

V – FINDINGS

SYSTEM OVERALL

[105] This analysis was possible because of a contractual arrangement the County has with Joseph P. Ryan, MSW, Ph.D., Assistant Professor, at the School of Social Work, University of Illinois, Urbana-Champaign.

[106] Involvement with child welfare in Los Angeles County includes any open or ongoing case between 2002 and 2005.

Finding: DCFS's current leadership has responded to national trends and reduced its reliance on group home facilities.

Under the leadership of Dr. David Sanders, Ph.D., DCFS has experienced greater cohesiveness in its mission. DCFS has acknowledged the national trends and began shifting emphasis away from group home facilities in preference to less restrictive placements. During the last five years, DCFS has reduced significantly the numbers of group home facilities and dependents placed in them. The percent of dependents initially placed in a group facility is declining and the total number of dependents in these facilities decreased from 2004 through 2006. See Table 5. CGJ was unable to obtain budget information over this time period.

Table 5: DCFS Placement Trends at Time of Initial Placement Versus Point-in-Time Placement, By Facility Types (2004 Through 2006)

Out-of-Home Care (Foster Care) Facility Types	2004	%	2005	%	2006	%
At Time of Initial Placement						
FFA Certified Home	2,938	49.1	3554	49.8	3737	50.9
Foster Family Home	1,010	16.9	983	13.8	895	12.2
Group Home	216	3.6	188	2.6	184	2.5
Relative Home	1,817	30.4	2407	33.8	2530	34.4
Total	**5,981**	**100.0**	**7132**	**100.0**	**7346**	**100.0**

Note: The above section of Table 5 contains the dependents' initial placements by facility type.

Out-of-Home Care (Foster Care) Facility Types	Dec 2004	%	Dec 2005	%	Dec 2006	%
Point-in-Time Placement						
FFA Certified Home	6,142	24.5	5,971	24.5	6,029	25.4
Foster Family Home	3,212	12.8	2,259	9.3	1,998	8.4
Group Home	1,991	7.9	1,800	7.4	1,559	6.6
Guardian Home	2,530	10.1	3,095	12.7	3,301	13.9
Relative Home	11,238	44.7	11,219	46.1	10,868	45.7
Total	**25,113**	**100.0**	**24,344**	**100.0**	**23,755**	**100.0**

Note: The above section of Table 5 contains dependents in Out-of-Home Care on December 31 of each calendar year by facility type.
Regarding Table 5:
1. Group Home includes County shelter care and medical facility.
2. Foster Family Home includes small family home, court-specified home and tribe-specified home.
3. The table excludes placements in Non-Foster Care and Adoptive Home - Adoption not Finalized
4. Data source is CWS/CMS Datamart as of 4/13/2007.

The portion of dependents placed in group home facilities versus other types of Out-of-Home care is declining; the portion placed with relatives is increasing. In March 2006, the County issued a white paper, entitled "Foundation for Los Angeles County's Utilization of Residential-Based Services (RBS) for Children – A New Understanding of the Role of Residential-Based

Services: Key Elements". Although many aspects of the child welfare system are improving, more change is needed.

Finding: Communication breakdowns occur across the system.

The child welfare system has a complex structure, which is further complicated by poor communication between and within departments and with the various caregivers. This communication breakdown is a result of several factors:

Many decisions have to be made under hasty conditions, particularly the initial placement of dependents entering DCFS.

Multiple people are involved with each child's case, including but not limited to social workers, probation officers, psychologists, psychiatrists, lawyers, educators, caregivers, CASA volunteers, and judges.

High turnover of the various involved parties creates an almost constant state of instability.

The lack of a comprehensive data system means records are difficult to find and retain for future reference and decision-making.

Confidentiality requirements frequently mean decisions are made without accurate or complete information.

PLACEMENT

Finding: Limited information and urgently made assessments exacerbate the instability of the child placement.

National trends. In addition to being older, children and adolescents in congregate-care placements have often remained in care for longer periods of time and experienced greater instability.[107] Dependents are rarely removed from the biological family home and placed directly into a congregate-care setting. Within the child welfare system, out-of-home placements begin in kin or non-kin foster family homes – and when such placements no longer work – the dependent is moved into more secure settings (i.e., congregate-care facilities). There are many reasons placements "don't work" but foster parents' being ill-prepared, non-supportive, or unwilling were the most pervasive, particularly when dealing with children's behavioral or emotional problems.

Los Angeles County experience. Because DCFS decisions are often made with little information, decisions are less than optimal. As a result, children are frequently moved from placement-to-placement because of behavior difficulties or other issues. As indicated earlier, during 2002-2005, 71% of the children had at least one placement in foster care, 53% had at least one placement in a relative's care, and 23% had at least one placement in a congregate-care facility. Placement stability was also problematic for that same time period: 49% of the dependents experienced at least three different placements. Approximately 9% of the dependents experienced a change in placement due to AWOLs and approximately 7% because of child behavioral problems.

[107] Courtney, 1998; Knapp et al., 1987.

Each placement change may also require a school change. The dependents and wards may also have to change CSWs or DPOs because of turnover and workload shifts. This instability and lack of a single, constant caring adult is detrimental to the children.

Finding: Given the nature of their wards and process, Probation can take a more methodological approach to initial placements than DCFS.

DCFS placements, particularly initial congregate-care placements, seem to be more problematic than Probation placements.

DCFS. DCFS placement decisions begin with the determination that a child must be removed from his/her home. DCFS dependents are usually placed in a rush and can end up in an inappropriate setting as a result. Technical Assistants (TAs) gather a list of about six group home vacancies while the CSW is retrieving the child from his/her home. Table 6 outlines the emergency response referrals for the dependents.

Table 6: Emergency Response Referral of Dependents
March 2007

Emergency Response Referrals		#
Evaluated Out (includes inquiries and other issues that do not warrant an in-depth investigation)		**1,484**
In-Person Response (CSW goes to the home to investigate allegation)		**13,941**
Allegation Disposed	*4,871*	
Allegation Disposition Pending (referrals still under investigation)	*9,070*	
Total Dependents Referred during the Month		15,425

The most common allegation triggering a DCFS investigation is general neglect, followed by a child at risk or sibling abuse, physical abuse, or substantial risk, listed in Table 7.

Table 7: Referred Dependents, by Allegation Type
March 2007

Referred Dependents, by Allegation Type	#	%
General Neglect	3,888	**25.2**
At Risk, Sibling Abuse	3,016	**19.6**
Physical Abuse	2,902	**18.8**
Substantial Risk	2,784	**18.0**
Emotional Abuse	1,216	**7.9**
Sexual Abuse	950	**6.2**
Caretaker Absence/Incapacity	499	**3.2**
Severe Neglect	156	**1.0**
Exploitation	14	**0.1**
Total	15,425	100.0

DCFS staff members indicate emergency placements are often done without much information about the children other than age and sex. The 1999-2000 Grand Jury had a similar finding. Even if the child has been in the DCFS system for awhile, privacy laws prevent CSWs from obtaining pertinent information about the child that could facilitate a better placement decision.

Probation Department. In contrast, because Probation placement decisions are guided by the court, initial out-of-home placement for Probation wards is relatively straightforward compared to DCFS. A judge makes the determination that a child will be placed in a congregate-care facility, camp, with relatives, or sent home on probation (HOP). Once a congregate-care placement decision is made, the DPOs at Probation's Central Placement Operation decide which type of group home is best for the child based on his/her needs. DPOs have access to court records and are usually not too rushed when placing a ward, thus enabling them to make fairly good decisions in regards to RCL level and the ward's specific needs. In April 2007, approximately 80% of the 1,373 wards were housed in RCL-12 or higher facilities.

Probation is currently taking multiple steps toward improving their assessments of wards to maximize interventions and therefore outcomes. In 2006, Probation started a pilot program whereby wards are sent to a Placement Assessment Center (PAC) for a 30-day comprehensive evaluation before being placed. Approximately 5% of the Probation population is currently being served by the two PACs at Boy's Republic and Rancho San Antonio – both large congregate-care facilities. Despite their size, the wards were kept out of the general population while being assessed. In January 2007, these wards were not integrated in the overall general population. The assessments involve multi-disciplinary teams, matching wards with placement options, coordinating goals, and preparing discharge plans.

Finding: Probation wards have greater placement stability than DCFS dependents in congregate-care facilities.

Wards have greater stability in congregate-care placement because they are in detention. They average 1 placement per ward and spend an average time of 6-12 months in that placement. In contrast, dependents have more factors that might cause placement changes and therefore have greater instability. Table 8 displays the average number of moves made by dependents.

Table 8: Number of Placement Moves for Dependents

Type of Placement	#
Group Home	**6.0**
Foster Family Home	**3.4**
FFA Certified Home	**2.5**
Relative Home	**2.3**

Source: UC Berkeley estimates for DCFS

Many DCFS dependents bounce from placement-to-placement throughout their association with the child welfare system. Probation wards are detained in the juvenile justice system and, therefore, are more likely to stay in their first placement for their entire probation sentence; the exception is the 2%-3% who go AWOL and then typically get transferred.

DCFS dependents placed in congregate-care facilities are transferred an average of six times before they leave the child welfare system. Those in various types of foster homes move about

one-half as often and those placed with relatives move even less frequently. DCFS has minimal protocol breakdowns of new dependents as to age or overall therapeutic needs for appropriate placement either temporarily or long term. There are limited initial assessments and collaboration with residential-based facilities to find a proper initial match. DCFS's philosophy that "group homes" are the last resort is also the philosophy of the courts. This philosophy leads to multiple failed placements and negative outcomes.

One common cause of replacement is when the congregate-care facility issues a 7-day notice to DCFS, requiring the removal of the child. This situation typically occurs when the congregate-care facility has difficulty dealing with behavioral issues. DCFS receives approximately 75 7-day notices per month through their main office, but DCFS officials said the actual number is higher because some notices go directly to the CSW.

Moreover, DCFS lacks a replacement strategy to ease the dependent into their new environment. Although DCFS's policies require transition meetings, they do not occur consistently – the dependent may be picked up and moved to a new foster or congregate-care facility. This trauma and instability can worsen the dependent's sense of security and well-being according to studies.[108]

Although Probation wards are not typically bounced around, they suffer when their probation period ends just before the end of a school year, thus requiring a change of school.

Finding: Adolescents are the most difficult to place in foster homes.

Adolescents are difficult to place in foster homes because they can be harder to handle than younger children. This difficulty is often because they have been in the system for a long time according to DCFS staff. Many adolescents are never reunited with their families and never find a permanent home through adoption or guardianship. Instead they "age out" of the system, spending their teen years with peers who also have behavior problems. "Placing anti-social and delinquent youth together in large group settings often has the unintended consequence of fostering delinquency and anti-social behavior,"[109] as discussed earlier.

Adolescent dependents go through an emancipation process, where they receive some training in life skills, such as opening a bank account and renting an apartment, although this education is minimal. A number of residential-based facilities devote themselves to serving adolescents and provide the infrastructure (e.g., transitional housing, job placement) to meet their social and emotional needs and achieve emancipation successfully.

Finding: DCFS and Probation do not perform a <u>long-term</u>, cost-benefit analysis of the optimal placement options.

Congregate-care facilities perceive that the County's current trend is to limit placements regardless of the children's and families' progress in treatment, related community safety issues, and issues related to the children's safety if returned home pre-maturely. Time-limited guidelines are barriers to motivation for behavioral change and promote an attitude of "doing time". Wards returning from meetings with DPOs and court would say: "In 5 more months, I'm

[108] Rubin, D. M., et al., Placement stability and mental health care costs for children in foster care, *Pediatrics*, 113(5), 1336-1341.
[109] Civil Grand Jury Presentation, Los Angeles County Probation Treatment Services.

out of here, as long as I don't violate the law." Family work, social training, and pro-social attitude development are undermined as a result of messages being sent to children.

Currently, Probation advocates for a 6-month time-limited program for their wards. Treatment orders which expire regardless of the ward's participation in treatment are a threat to community safety, program credibility, and stabilization of any treatment. Length should be determined by the ward's progress in treatment.

In the short term, placing dependents in congregate-care facilities is a much more costly option than foster family homes or FFA-certified homes:

Congregate-care facilities range from $2,589-$6,371 per month, depending on RCL level.

Foster family homes are just $425-$597 monthly, depending on the age of the child.

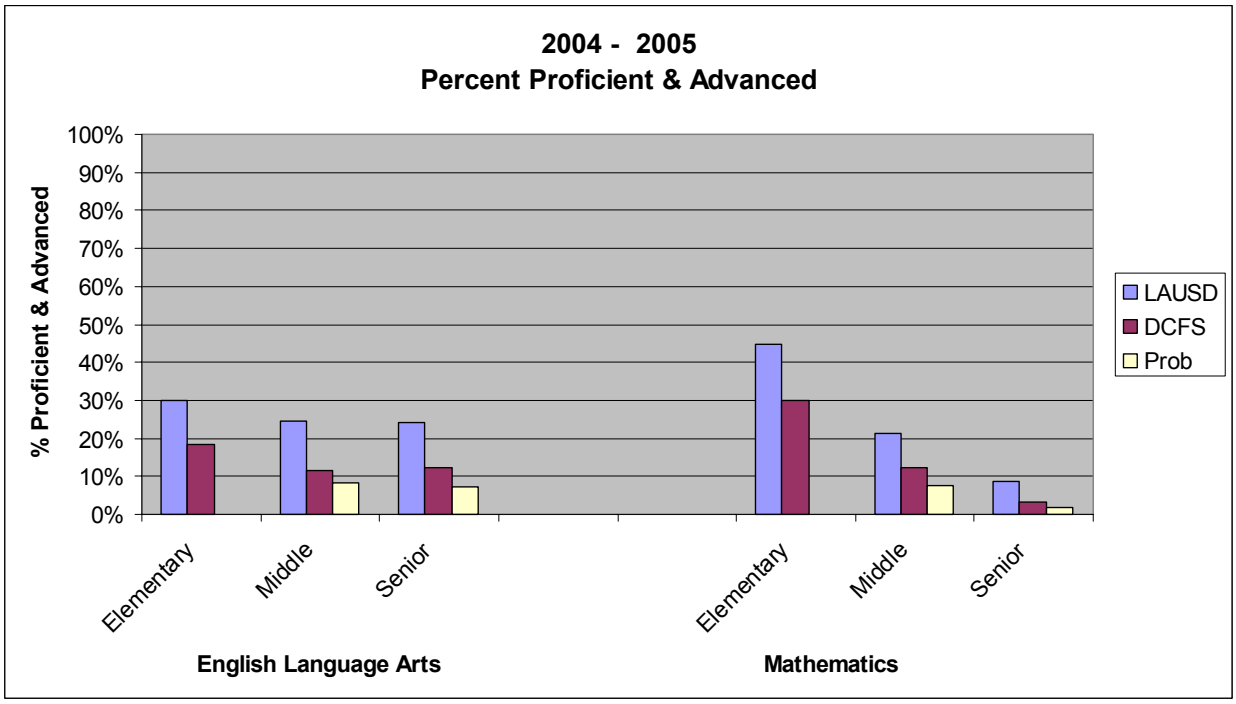
FFA-certified homes cost about the same as foster family homes, unless the child receives treatment in which case the range is $1,589-$1,865.

In the longer term, the residential-based facilities may be more cost-effective if the outcomes result in reduced recidivism and crimes and higher educational levels that translate into greater earning power over one's life time. At this time, however, DCFS and Probation do not empirically consider such factors.

EDUCATION

Finding: Placement instability and other negative factors have led to educational achievement deficiencies.

Consistent with other research studies, placement instability and other negative factors (e.g., the troubled home life of dependents in the child welfare system) have predictably resulted in educational achievement deficiencies in Los Angeles County, as shown in the next figure.



	# of Students	% Gifted Students	% Students with a Suspension	Average Days Suspended	% of Dropouts, Grades 7-12	% of Board Expulsions
LAUSD	727,099	8.7	7.6	1.5	2.0	0.05
DCFS	8,027	2.5	12.2	1.8	3.9	0.09
Probation	2,746	1.2	77.8	2.7	24.4	5.75

Recent studies of Los Angeles Unified School District (LAUSD) and Pasadena Unified School District (PUSD) indicate that, overall:

DCFS dependents fall substantially behind their peers in all academic subjects.

Probation wards are even further behind.

Suspension and expulsion rates are much higher for these groups.

Geographic instability is part of the problem but not the whole problem. DCFS has a policy to set educational goals and assign needed resources for dependents; however, the policy has yet to be fully executed.

In November 2004, the Los Angeles County Board of Supervisors created the Education Coordinating Council (ECC) to raise the educational achievement of children in both the child welfare and juvenile justice systems by providing oversight and accountability. This 23-member Council includes representatives of relevant school districts, juvenile court, advocacy and planning groups, community agencies, children and their caregivers, and several County departments. The ECC works to encourage the various organizations to work together to fill gaps in the community by providing resources to these underserved children. Progress thus far

includes: a) a fee waiver for foster parents so that dependents can attend Los Angeles Universal Preschool and b) the development of a process so that dependents and wards can better access LAUSD's Beyond the Bell after-school programs. ECC has also facilitated a preliminary data match program between DCFS and LAUSD so that descriptive statistics can be collated.

Beginning in 2004, children requiring special education and attending Non-Public Schools (NPS) were required to have Individual Education Plans (IEPs); however, the congregate-care facilities do not always have access to the IEPs when children are placed with them. Children are periodically placed in new settings without considering their need to finish the school term or year. At other times, children are placed in new settings but follow-up is not consistent to verify that the children are enrolled promptly in their new schools.

INTERVENTION MODELS

Finding: The Federal Title IV-E Waiver will permit the County to deliver services in a more flexible and tailored manner.

The U.S. Department of Health and Human Services (DHHS) will grant to the State of California waivers of certain provisions of Title IV-E of the Social Security Act "for the purposes of implementing a flexible funding demonstration project."[110] This waiver will allow the State to disperse funds to selected counties to provide services "… to children and families regardless of their previous Title IV-E eligibility." The goal of this waiver is to improve the array of services for children and families, allow for a more individualized approach to those services, increase child safety without an over-reliance on out-of-home care, improve permanency outcomes, and improve child and family well-being.

The Title IV-E Waiver has made it possible for California and Los Angeles County to develop new child welfare programs. Los Angeles County sees the benefits of the Title IV-E Waiver[111] for its congregate-care facilities. Congregate-care will be provided when a child cannot be effectively or safely treated in a family environment. Such facilities will be redefined and their responsibilities expanded to include family support services and post-discharge (aftercare) services. RBS will be used as an intervention, offering targeted treatment, and not just housing. Improved initial assessments should discourage congregate-care facilities from being used as default option for placement. Dependents and their families should be fully engaged in the treatment and permanency planning.

Finding: DCFS is implementing treatment models that are more cost-effective and predict better outcomes.

A shift towards preventive services has taken place in the County during the past several years. In addition, Federal funding via Title IV-E Waiver provides money for pro-active services to

[110] Department of Health and Human Services, Child Welfare Waiver Demonstration Project.
[111] Foundation for Los Angeles County's Utilization of Residential-Based Services (RBS) for Children (March 31, 2006).

prevent children from entering the child welfare system.[112] The County of Los Angeles is in the process of implementing the following treatment models:

Prevention Initiative (PI). The County is also pursuing the Prevention Initiative (PI),[113] which is rooted in the belief that children end up in the care of child welfare agencies because of weak families and communities. The basic PI goals are to strengthen families and communities, thus providing a safer, healthier environment for children, and eliminate the need for further DCFS services. DCFS has funding of $5 million for developing and launching the PI Implementation Plan in 2007-2008.

Adaptations of the Treatment Foster Care (TFC) model, called the Multidimensional Treatment Foster Care (MTFC) program and Intensive Treatment Foster Care (ITFC) program – DCFS is working with the Department of Mental Health (DMH) to develop 80 slots of MTFC and is considering developing several hundred homes under the ITFC program. MTFC is promising but has numerous obstacles to overcome, including the long licensing process, getting foster parents to shift their thinking from an independent fostering style to a team-oriented style, and the potential problem of removing all the best foster parents from the current system.

Wraparound Services. According to Probation, Wraparound Services are based on "… individualized, strength-based, needs-driven planning and service delivery." The CGJ prescribes to the Wraparound Services argument that it is "… not something you 'get', it's something you 'do'; it's a process, not a program."[114] The County's Wraparound Services include a wide variety of psychological, educational, and other services to assist the child to remain in a home environment.

Johnny's Story

In the middle of the night, Johnny was placed in a group home facility without any initial assessment and coordination with the facility. A CSW requested Wraparound Services be provided to Johnny by a private enterprise. At the same time, the group home facility provided similar services, required by his RCL-8 rating. This lack of coordination can result in duplication of efforts and potentially conflicting intervention treatments. In summary, Johnny was rejected by his family, placed on an emergency basis in a group home facility, and shunted to other places for duplicated treatment, causing further disruption and trauma[115].

If not well coordinated, Wraparound Services can create more fragmented and redundant services. Wraparound Services are only available to children who are adopted, placed with legal guardians, or being reunified with their families. Sites visited by the CGJ had a range of Wraparound Services.

The DCFS's policy manual prescribes Wraparound Services for dependents at RCL-12 or higher. On the basis of the CGJ's observations, it seems to work better when implemented at lower RCLs. Wraparound Services appear to be more appropriate for in-home or foster-family care settings, where additional supportive and therapeutic services are not being provided, and during

[112] DCFS Press Release, April 3, 2006.
[113] Los Angeles County, Prevention Initiative (PI) Implementation Plan (10/27/06 draft).
[114] Juvenile and Emerging Adult Care and Service Continuum, OJJDP, April 2000.
[115] CGJ documented this example during an on-site visit at a group home facility.

transitional periods. The system also lacks team decision-making and criteria regarding the indications and duration of services needed.

MENTAL HEALTH

Finding: Exacerbating the situation further are the mental problems that many of the adolescents in the system struggle with, which resulted in the Katie A court case.

One study estimates that nearly 70% of children in California's foster care system will experience mental health problems[116] and "50,000 children who may need mental health services do not get them."[117] In March 2006, the State of California was ordered to provide virtually unlimited mental health services to dependents in foster care, or at risk of foster care placement, by Federal District Court Judge Howard J. Matz via his ruling in the *Katie A. et al v. Diana Bonta* case.[118] Instead of addressing mental health needs, plaintiffs indicated that DCFS moved these children from one inappropriate placement to another, and warehoused them in psychiatric or temporary facilities when there were no other slots in which to place them.[119]

Los Angeles County recently agreed to a Memorandum of Understanding (MOU) to address the mental health needs of DCFS dependents in RCLs or at-risk of being placed at RCL-12 or higher. These dependents are to receive: a) prompt mental health services in a family environment, b) the services necessary to help prevent removal from their home, c) the resources and services needed to avoid multiple placements whenever possible, and d) good quality mental health care. *Katie A.* increases the availability of Wraparound Services and develops Therapeutic Foster Care (TFC) support. The whole area of mental health of dependents and wards is a large topic worthy of its own investigation.

[116] Alpert, Michael A., Young Hearts & Minds: Making a Commitment to Children's Mental Health. California Little Hoover Commission, 2001.
[117] *Ibid.*
[118] *Youth Law News*, April-June 2006.
[119] First Amended Complaint for Declaratory and Injunctive Relief at 5-9, Katie A. v. Bonta, No. CV02-05662 (C.D.Cal. filed Dec. 20, 2002).

INFORMATION TECHNOLOGY (IT) AND EVIDENCE-BASED RESEARCH

Finding: The County lacks comprehensive databases and the resources to conduct longitudinal studies that can help them make evidence-based decisions.

The current DCFS and Probation information systems are inadequate. Criticisms involve lost records, delays in getting information, incorrect information, and lack of access to key information that could result in better care for the children.

DCFS and Probation have had difficulty providing basic information for this CGJ investigation. Many of Probation's statistics had to be hand tabulated from manual records. In almost all cases, estimates had to be developed by the Departments in lieu of actual counts. DCFS has a computerized system for tracking Special Incident Reports (SIRs) regarding children in congregate-care setting, but it is not readily used to analyze trends.

Many factors – lack of resources, expertise, time, and commitment – impede conducting meaningful research. The County departmental data systems are not sophisticated. CSWs and DPOs enter much of their information manually into the system. Data fields are incomplete. Few databases are shared and track children across County departmental services rendered.

Currently no longitudinal studies of outcomes exists, thus making it difficult to gauge which programs are working and which ones are not. The County has entered into two research projects with: a) the School of Criminal Justice & Criminalistics at California State University at Los Angeles[120] and b) the Children and Family Research Center in the School of Social Work at the University of Illinois.[121] This Center is now statistically analyzing trends in the County for this target population; its data and analysis were critical input to this CGJ investigation.

STAFFING

Finding: Both DCFS and Probation have very high caseloads.

Large caseloads are a problem for both DCFS and Probation. CSWs and DPOs have too many cases and simply do not have enough hours in the day to give them all optimal care and attention. Most CSWs only see each charge for just one hour per month. In addition, relatively high workloads with relatively low pay lead to high staff turnover.

DPOs handle between 50 and 55 wards each, according to Probation officials. Each ward is required at least one visit per month. In addition, the DPO needs to visit the ward's parents monthly and do all the relevant paperwork. As the wards and families are often scattered all over the County, the DPOs spend much of their time driving. In some cases, wards have moved out of the County or even the State – these wards must also be seen monthly.

Probation currently has 35 vacancies, which they have had difficulty filling. One reason cited is the lack of affordable housing in the greater Los Angeles area. Many potential candidates are unwilling to travel the long distances from where they can find affordable housing to various work sites. This high vacancy rate increases the caseload for current DPOs.

[120] Led by Denise C. Herz, Ph.D.
[121] Led by Joseph P. Ryan, MSW, Ph.D.

Another factor adding to the workload is the lack of efficient data systems, as noted earlier. Accessing data stored in this manner is extremely time-consuming; information is difficult to find and often lost. Physically moving paper files between offices is time-consuming, although Probation now uses a courier service rather than U.S. Postal Service. There is also a lack of database sharing, which makes it difficult to transfer or share information between departments.

DCFS strives not to change CSWs except when someone moves or the child needs a more experienced social worker. DCFS staff members indicate that the reassignment of CSWs has declined during the last decade but the turnover rate is still unacceptable.

CONGREGATE-CARE SETTINGS

Finding: DCFS and Probation have different viewpoints of congregate-care facilities.

The County has the full range of congregate-care facilities. On the well-run side are sophisticated, caring residential-based facilities that make a difference in children's lives. On the negative side, some group home facilities are inadequately staffed and function basically as places to warehouse children. Because children's needs vary, the County will always need the full continuum of services, including well-run group home facilities and residential-based facilities.

Probation Department. Probation is developing decision-making protocol that would determine placement decisions based on risk level, mental health needs, education competency, and age. Most of Probation's wards are placed with a relative (home on probation (HOP)). For those not eligible for HOP, Probation views congregate-care facilities as a less restrictive environment to the camps, a locked facility. As shown in Table 9, fewer Probation wards (26%) are placed in congregate-care facilities versus camps (39%). Juvenile Hall (33%) is a temporary detention until a placement decision is made.

Table 9: Profile of Wards Entering the Juvenile Justice System and Assigned to Out-of-Home Situations On a Given Day in April 2007

Type of Placement	Number	%
Camp	2,028	**39%**
Juvenile Hall[122]	1,711	**33%**
Congregate-Care Settings	1,373	**26%**
Suitable Placement Order with Relative or Non-Relative	87	**2%**
Suitable Placement Order with Parents	16	**<1%**
Total in System	5,215	100%

The usual stay in a congregate-care setting is 9-12 months, according to Probation management. Some wards prefer to go to a camp – a more restrictive environment – because they can end their probation period quicker than if placed in a congregate-care setting.

[122]This is the number of wards temporarily assigned on a single day in April 2007.

DCFS. In contrast, congregate-care facilities are the most restrictive, limited to dependents with intensive treatment needs, and often lack a family atmosphere. High turnover in staff combined with the realities of shift work mean the dependents in these group home facilities lack the stability of having one committed adult in their lives. Dependents placed in congregate-care facilities spend an average of almost 700 days in group home facilities during their DCFS tenure. When appropriately placed in a congregate-care setting that complies with DCFS standards, however, the children's needs can be met.

Some within DCFS view RCL-12 facilities as the "last resort" placement for dependents. DCFS CSWs are pressured to make timely placements of dependents and are frustrated when they perceive that some RCL-12 group home facilities are being "overly" selective, making it difficult to place the most challenging dependents. They refer to this selectivity as "creaming", the practice of taking the least difficult dependents and rejecting others after reviewing their records or conducting interviews. Pregnant teens and those with small children of their own are difficult to place.

In contrast, the RCL-12 group home facilities justify their need to be selective because some dependents' needs are not a match with the kinds of children they help the most; in addition, some RCL-12 group home facilities are not in a position to deal with certain types of dependents, such as children who start fires, are gang members, or are drug dealers.

Finding: Children in congregate-care facilities have a different demographic profile, erratic caretaker history, and more placement instability, compared with dependents placed in other out-of-home placement settings.

On the basis of the 2002-2005 records, the County populations served in congregate-care facilities and other out-of-home placement settings differed. The County sample includes children with at least one episode in out-of-home placement that lasted at least two weeks in duration (n=53,095). Within this sample, 6,422 (12%) children had at least one congregate-care placement. Significant differences emerge on almost every characteristic:

Youth in congregate-care placements are:

- Significantly older (13.3 years vs. 6.7 years)
- More likely to be male (56% vs. 48%)

Regarding the reason for placement, children in congregate-care facilities are less likely to have a history of general neglect (21% vs. 33%) but more likely to have a history of:

- Physical abuse (15% vs. 10%)
- Caretaker absence (33% versus 26%)

Regarding placement instability, ***children in congregate-care facilities experience significantly more changes in placement*** (6.0 vs. 3.0).

Regarding case duration, the cases for children in congregate-care placements remain open for significantly longer periods of time (6.2 years vs. 4.4 years).

Finding: Children in congregate-care facilities have a greater propensity to engage in delinquency.

National trends. ***Prior research has clearly established a relationship between disruptions and transitions within the family system and delinquency.*** On the basis of a sample of 4,000 children and interviews completed every six months with children between 13 and 18 years of age, children in urban areas were likely to experience at least one disruption or transition during adolescence; approximately 45% of the sample experienced two or more changes in family units.[123] These changes had a significant effect on the probability of delinquency. In Pittsburg, 90% of the children with five or more disruptions or transitions reported engaging in delinquent behavior.[124]

Specific to foster care, placement instability is associated with a range of negative outcomes, including child behavior problems, feelings of insecurity, and overall dissatisfaction with the foster care experience.[125] In part, the problems associated with placement instability inspired the development of Federal initiatives intended to increase family permanence for children who otherwise would languish in long-term foster care.

Although congregate-care facilities may be supervised by child welfare (i.e., DCFS in Los Angeles County), the adolescents living in these homes are often involved with other social service agencies. In a recent review of residential placements in New York State,[126] an increasing number of children are entering congregate-care facilities with a history of psychiatric hospitalization, psychotropic drug use, delinquency, and substance abuse. These changes represent a significant departure from the facility models serving only abused and neglected individuals.

Los Angeles County Experience: The placement instability literature focuses almost exclusively on the frequent movements dependents experience and the negative outcomes associated with such movements. Prior research has yet to pinpoint the exact timing of the delinquent event in relation to the congregate-care placement. That is, are congregate-care dependents more likely to offend subsequent to their placement? This CGJ investigation is different because it focuses on determining whether delinquency is associated with the frequency of movements or the reasons associated with each movement, such as placement disruptions that result from running away (AWOL) and for reasons associated with child behavioral issues (other than delinquency).

Los Angeles County children entered the observation period (2002-2005) at different points in time. For example, a child may be 8 years of age in 2002. In general, children younger than 9 years of age are not processed in the juvenile justice system. Thus, the 8-year-old is only at risk of delinquency for approximately three years (2003-2005). In contrast, an adolescent that is 10-years-old in 2002 is at risk for the entire observation period. In short, the children are exposed to the risk of delinquency for varying lengths of time. The average time at risk in the current study is 1,384 days (3.7 years). The sample was selected so that all children are at risk for at least one year. The results of this analysis were consistent with prior studies; the overall risk of delinquency in the general population is as follows:

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[123] Data from three longitudinal studies: Rochester Youth Development Study, Denver Youth Survey, and Pittsburg Youth Study.
[124] Thornberry, Smith, Rivera, Huizinga, and Stouthamer-Loeber, 1999.
[125] Festinger, 1983; Kurtz, Gaudin, Howing & Wodarski, 1993; Redding, Fried & Britner, 2000.
[126] Dale et al. (2007).

- Males in the County child welfare system are more likely to engage in delinquency as compared with females in the child welfare system (14% vs. 7%).
- African-Americans have the highest risk of delinquency (13%) as compared with Hispanics (9%), Whites (8%), and Asians (5%).
- The risk of delinquency is significantly lower for placements associated with neglect (9%), as compared with placements associated with physical abuse (12%), sexual abuse 13%), and emotional abuse (14%).
- Adolescents with four or more placements were more likely to experience delinquency relative to adolescents with three or fewer placements (16% vs. 7%).
- Adolescents with at least one congregate-care placement are at an increased risk of delinquency (22% vs. 7%).
- Movements associated with AWOLs (30% vs. 9%) and child behavioral problems (24% vs. 9%) increase the likelihood of delinquency.

Violent offenses, followed by burglary, represented more than one-half of the delinquent offences. Of the 2,106 children with at least one delinquency offense, 24% were associated with a violent offense, 17% burglary, 5% weapons, 5% terrorist threats (i.e., threats of physical violence), 4% drugs, and 3% sex related.

Males, adolescents in congregate-care facilities, and AWOL youth have the greatest risk of committing subsequent delinquency. Gender, congregate-care setting, and AWOLs have the biggest impact on subsequent delinquency. The relative risk of delinquency is approximately:

- Two times greater for males as compared with females in substitute care placements
- More than two times greater for adolescents with congregate-care placements
- Three times greater for adolescents with a history of running away (AWOL)

Similar to prior studies of maltreatment and delinquency, African-American and Hispanic adolescents experience an increased risk of delinquency relative to White or Asian adolescents. There is no difference of relative risk when comparing White and Asian adolescents.

The statistical analysis indicates that it may not be placement instability itself that is responsible for an increased risk of delinquency but rather the circumstances associated with particular changes in placement: relocation of foster parents, placement with siblings, and moving adolescents into less secure environments. The majority of arrests occur while adolescents are in placement or on the run from placement:

- Of the 2,106 adolescents with at least one arrest, 1,671 (79%) of these adolescents experienced their first arrest in a substitute care placement setting.
- Of the 1,671 adolescents arrested in placement, 675 (32%) occurred while placed in a congregate-care setting.
- Only 23% of children have congregate-care placements yet the congregate-care setting is where approximately one-third of all arrests occur. Each congregate-care placement lasts an average of 5.5 months.

Adolescents are more likely to enter foster care (relative or non-relative) and spend more time in foster care, yet the percentage of adolescents arrested in these placements is significantly less than that associated with congregate-care setting.

The timing of arrests is an important distinction as it addresses whether there is a lingering facility effect or whether the experiences and impact of the facilities are more immediate. An adolescent slowly adopting values and beliefs consistent with a deviant lifestyle – and then acting upon those beliefs subsequent to their release from the congregate-care setting – might be indicative of a lingering or sleeper effect. Yet the adolescents in the current investigation are arrested during their congregate-care placement – perhaps indicating that the effect of these placements is more immediate. Thus, ***congregate-care placements appear to increase the risk of delinquency***; between 2002-2005, 2,106 (10.4%) of 20,309 adolescents in placement had at least one arrest subsequent to their first placement episode. Moreover, the rate of violence-related offenses is greater than the rate reported for the general delinquency population.

Finding: Congregate-care placements impede permanency outcomes.

In the CGJ's longitudinal study, these analyses are limited to the placement cases that closed in Los Angeles County between 2002 and 2005 (n=32,197). They were reviewed to understand the relationship between congregate-care placements and each outcome: family reunification, permanency, and adoption.

The effects of a congregate-care experience are significant in relation to permanency and adoption even when controlling for age, race, gender, and placement instability. These differences are primarily due to the differences associated with the adoption rate. Only 3% of congregate-care cases close in adoption, compared with 21% of the foster care cases. In short, ***congregate-care placements significantly decrease the chances for achieving permanence***, and this effect is largely attributed to differences with adoption rather than family reunification. There are no significant differences with regard to achieving family reunification. Moreover, older and African-American or Hispanic adolescents are less likely to achieve adoption or family reunification. ***Placement instability significantly reduces the likelihood of achieving family reunification.***

As shown in Table 10, most dependents are reunited with their family (42.7%) or guardian (23.0%); others are adopted (10.3%); and others are emancipated at age 18 (7.4%).

Table 10:
How Dependents Exit the Child Welfare System

Exit Options	#	%
Family stabilized (FM)	8,695	**42.7**
Re-unified with parent/guardian	4,686	**23.0**
Adoption finalized	2,079	**10.3**
Emancipation/age of majority	1,517	**7.4**
Guardianship established	1,145	**5.6**
Refused services	863	**4.2**
Services provided by other agency	457	**2.2**
Judicial (arrested)	373	**1.8**
Exceeded time limit	366	**1.8**
Child runaway or abducted	159	**0.8**
Death of child	49	**0.2**
Child committed to state hospital	0	**0.0**
Total	**20,389**	100.0

Source: UC Berkeley estimates for DCFS

Table 11 displays how wards exit from the juvenile justice system. The majority end up in HOP (34.0%), followed by going AWOL (30.0%), being arrested (19.8%), or serving out their probation term (16.1%). ***Overall, 49.8% had negative outcomes – going AWOL or being arrested.***

Table 11: How Wards Exit Congregate-Care Settings

Exit Options	#	%
Home on Probation (HOP) – wards returned to parents/caregiver, but still on probation	537	34.0
AWOL – wards who are caught and returned to court; wards never found (475 is approximate)	475	30.0
Judicial – wards arrested and sent to either a Probation camp or a State-operated Department of Juvenile Justice facility for more serious crimes	312	19.8
Probation ends – Jurisdiction terminated, ward no longer on Probation	255	16.1
Death	1	0.1
Total	**1,580**	**100.0**

Source: Probation Department, July 1- December 31, 2006 actual numbers

Finding: The practice of placing dependents and wards in the same congregate-care facility is ill-advised.

Social psychologists posit that context profoundly influences one's thoughts and behaviors in peer group settings. In fact, peers are perhaps one of the most powerful agents of influence. American adolescents report that peers both encourage and discourage: (1) anti-social behaviors, (2) conformity to peer social norms (e.g., dress, grooming), and (3) academic performance.[127]

[127] Brown, Clasen, and Eicher, 1986.

Therefore, this County practice is suspect. Table 12 displays the estimated number of children assigned to congregate-care facilities, by RCL level.

Table 12: Number of Children in Congregate Care, by RCL Level
March 2007 (Estimates)

RCL	Number of DCFS dependents	Number of Probation wards	Total		Dependents in DCFS-only group homes	Wards in Probation-only group homes	DCFS dependents in mixed group homes	Probation wards in mixed group homes	Total
14	65	11	76		53	0	12	11	76
13	0	0	0		0	0	0	0	0
12	692	771	1,463		373	366	319	405	1,463
11	235	49	284		223	5	12	44	284
10	102	153	255		100	149	2	4	255
9	83	47	130		75	38	8	9	130
8	68	0	68		68	0	0	0	68
7	33	0	33		33	0	0	0	33
6	12	7	19		10	6	2	1	19
5	0	88	88		0	88	0	0	88
4	0	28	28		0	28	0	0	28
Totals	1,290	1,154	2,444		935	680	355	474	2,444

Although the majority of the dependents (n=935) are in DCFS-only homes and the majority of wards are in Probation-only homes (n=680), many are placed in mixed homes: 355 dependents and 475 wards. This mixing of children is problematic and not a best practice.

Finding: The quality of congregate care is impeded by current funding levels.

Congregate-care settings, FFAs, and foster family rates have not increased since July 1, 2001; therefore, these rates have not kept up with inflation. Many congregate-care settings embark on aggressive fund-raising campaigns to solicit funds to supplement the gap between what the County reimburses them and the actual costs. Five Acres raised $100,000 to supplement what the County gives for the residential program. Private donors implemented scholarships for students, who must leave at age 18 but have no home, parents, or providers.

When funding levels are insufficient, CSWs report that:

Some group home facilities may use interns or psychologists not specializing in the relative field instead of qualified therapists.

Some group home facilities may not properly train and motivate their staff, thereby, impeding the quality of care dependents are given.

PERFORMANCE MONITORING

Finding: Monitoring activities are fragmented but efforts are in place to measure performance.

The State, Auditor-Controller, and DCFS monitor congregate-care facilities and FFAs. This monitoring is fragmented and incomplete.

State of California. The Department of California Children Services (DCCS), Community Care Licensing Division, licenses the facilities and conducts annual inspections.

Office of the Auditor-Controller. The Auditor-Controller reviews all congregate-care facilities semi-annually. The creation of a separate audit within the Office of the Auditor-Controller was made in response to an earlier CGJ report. This separation has satisfied the board of Supervisors' concerns. However, documentation to show the impact providers have made to improve the overall well-being of children placed in their facilities as a result of these reviews has not been formally established. Social Workers, through the Auditor-Controller, use a standard audit instrument to ensure compliance with the County contract and State regulations when performing their audits. The Auditor-Controller requires facilities to prepare corrective action plans and prepares and publishes reports with the results of their reviews. In addition, the Auditor-Controller conducts periodic follow-up reviews to ensure facilities have corrected the noted problems.

Although, the Auditor-Controller maintains statistics on these reviews, this information is primarily used internally and is not routinely shared outside of the Department. The Auditor-Controller's audits run parallel with the DCFS audits. However, the Auditor-Controller does not have the criteria to establish lists of "Do Not refer" and "Do Not Use" facilities in conjunction with DCFS.

DCFS. DCFS's Performance Management Section conducts outcome-based performance reviews of congregate-care facilities and FFAs. Outcome-based performance reviews was a recommendation in the 1999-2000 Grand Jury report. The DCFS reviews are conducted to determine whether providers are meeting requirements set forth in their contracts and are adhering to DCFS policies in the areas of safety, permanency and well-being. A Corrective Action Plan (CAP) is required whenever deficiencies are found. DCFS currently has 11 staff members who monitor congregate-care facilities and 11 for FFAs.

DCFS has a quarterly report on individual children; however, there are no data or analysis to inform how effective various agencies are functioning. Without accurate data to review trends and patterns, it is difficult to create valid action plans for improvement. CSWs, DPOs, and auditors review individual files of children to check court-authorized psychotropic medication, including dosage levels and any reductions over time.

In 2006, DCFS began developing a Performance Measures Scorecard, which will measure the agencies on numerous criteria. Data will be collected by reviewing personnel records, assessing dependents' case files, and conducting child interviews. Complete group home facility inspections are not part of the process. DCFS will release preliminary scorecards and will give providers four weeks to review them. The final scorecards will be released July 15, 2007. The performance measures will be ongoing and scorecards will be released annually.

According to CSWs, minimal consequences currently exist for congregate-care facilities that do not live up to their obligations. For instance, there are few penalties if site personnel fail to get children to their regular appointments. DCFS and Probation have "Do Not Refer" and "Do Not Use" lists of service providers but the criteria used were unclear. One facility was finally closed after three years; there was no time frame for termination, however.

There are a number of considerations when the County assumes the role of parenting. There is the issue of providing resources to meet essential, basic needs, such as home and shelter, safety, food, clothing, and medical care. Higher levels of needs include education, mentoring, transmission of culture, socialization, and self-actualization (Maslow's hierarchy of needs) and are also the responsibility of the County. The County should do more to monitor these higher-level needs.

Finding: Congregate-care management and others complain about the system.

Congregate-care management complains that DCFS dependents often arrive with poor documentation. Caregivers do not know the child's history; for instance, is he/she violent or have other pertinent issues? Medical orders and other important documentation are often unavailable. Dependents who arrive in a crisis mode (e.g., in the middle of the night) are more likely to be improperly placed. One group home facility supervisor said that, in early 2007, DCFS began to include them in placement meetings, which is improving the process.

According to facility staff, dependents know their rights in the system and often act out because they know there are no consequences. Police tend not to arrest adolescent dependents for threatening or intimidating staff or residents; they will make the arrest if the adolescents appear that they may physically hurt someone.

Children and others can call the Group Home Ombudsman Hotline 24/7 with complaints about a facility or personnel. The majority of the calls are requests for information, but about 15-20 calls per month require formal investigation.

The situation for DCFS dependents has improved since 1999-2000 with new leadership, according to DCFS management.

VI – RECOMMENDATIONS

These recommendations build on an earlier Grand Jury report on Foster Family Agencies (1999-2000). Some of these present recommendations are needed because DCFS made inadequate progress in addressing these concerns over this 8-year period.

Effective July 1, 2007, the County of Los Angeles is establishing an Office of the Chief Executive Officer (CEO) to replace the former Office of the Chief Administrative Officer (CAO). These recommendations set forth specific actions within this new County structure.

Recommendation 1: The Board of Supervisors should study ways for Probation and DCFS to develop and evaluate up to 5 pilot projects designed to prevent and reduce the number of new dependents and wards in the system.

The standard approaches to prevention are general public education and intervention in high-risk homes (when they can be identified). Successful prevention strategies in both delinquency and dependence cases is likely to require a multi-faceted approach.

The Board has previously provided funding to the Service Integration Board (SIB) and some projects are underway in the District Attorney, CAO, and other departmental offices to mitigate some of the factors that effect the generation of new cases. Both Probation and DCFS need to study how to best accomplish this priority and participate effectively in the important integration efforts.

The purpose of this recommendation is to challenge the Departments to experiment with and propose new ideas.[128] Such innovation should be accomplished by bringing together multidisciplinary teams from within and outside the Departments to develop new prevention strategies on a pilot basis. Relevant nonprofit organizations, community groups, academicians, and professional consultants should also be involved. The pilot projects should include a strong evaluation component with assessments at the end of two years; at which time, the County determines the level of success of the pilots and the viability for sustaining or replicating these pilots elsewhere. The County should undertake at least 5 pilots to increase the chances of developing and implementing effective solutions quickly.

One of the key parts of the effort, led by the County Auditor-Controller, should be the development of an estimate of what an average child entering the system costs. The estimate should include all potential cost components, including: a) ***lost productivity over a life-time as a result of a negative life trajectory*** and b) the explicit "out of pocket" costs while these children are in the child welfare, juvenile justice, and possibly adult justice and welfare systems. This estimate will help the Board make its "investment in prevention" decision once the pilots identify the most effective prevention strategies.

Recommendation 2: Probation and DCFS should develop more sophisticated approaches to evaluate, monitor, and measure success.

The Departments should establish holistic evaluation approaches that consider both quantitative and qualitative components.

Recommendation 2.1: Probation and DCFS should develop a better set of outcome goals and measurements that monitor how the system affects a child's life trajectory.

DCFS should proceed with its newly developed Performance Measures Scorecard, a good starting point for effective measurements and monitoring. DCFS's primary focus of the scorecard and in the past has been on the important issues of child safety, shelter, and food. While attention is also paid to achieving positive supports for physical and mental health and education, it has not been sufficient to reverse the poor societal and educational results of

[128] DCFS leads a work group developing a proposed Demonstration Project; actual implementation will depend on whether the legislature passes AB 1453.

children in the system. Probation has not kept pace and their measures are rudimentary because of limited resources.

DCFS and Probation should develop measures that assess the quality of care and other outcome measurements.

- Probation and DCFS pay attention to "recidivism" – the return of children to the system for a second time (or multiple times). It is one measurement of the failure of the system. Under various Federal and State requirements, DCFS also has a goal to reunify dependents with their parents.
- DCFS and Probation should follow the children over the longer term to see how they fare in society.
- In addition to reviewing administrative data, DCFS and Probation should collect survey data for dependents and wards moving through the child welfare and juvenile justice systems. The survey should capture measures of well-being in such areas as academic, psychological, and social adjustment.
- The County should establish good measurements of the results of the myriad of interventions and programs currently in place for these children. Without such measurements, there is no systematic way to allocate its limited resources in optimal ways.
- The County should not focus solely on the short-term costs but weigh the current costs against the life-time savings to government if the wards and dependents become adults who are contributing members of society. (This concept builds on Recommendation 1 and the need for the Auditor-Controller to develop short- and long-term cost estimates.)

For instance, there is some evidence that the 9-month mark in residence is a critical negative turning point for many children; however, in this CGJ investigations, those campus-based facilities who are successful have reversed the downward spiral and are providing safe, stable, well-nurturing (albeit temporary) environments. Such environments do create a long-term sense of positive well-being with some very troubled youth. If this reversal could be proven from evaluative research that focuses on systemic outcomes for thousands of children, it would have a significant impact on how the services are provided.

In developing these new output goals, DCFS and Probation should reach out to and include the multidisciplinary groups of professionals who are currently involved in the children's lives. It may be wise to have this process facilitated by someone who will constantly challenge the status quo ways of thinking about the system, the current programs, and the children.

The incorporation of benchmarks and timetables that require regular progress reports to the Board would add a sense of urgency and importance to measuring and attaining the goals.

Recommendation 2.2: DCFS and Auditor-Controller audits should be integrated into a single, comprehensive audit function.

The external evaluation approach should be more sophisticated and the audits by DCFS and Auditor-Controller staff should be combined and tracked over time. These integrated audits should be conducted by using the experienced and qualified staff from both departments. The County should establish higher quality assurance levels for these audits.

Recommendation 3: DCFS should implement new treatment models that are evidence-based and proven to be successful.

Recommendation 3.1: DCFS should develop new categories of Foster Family Care that will have the skills and ability to parent the more challenging dependents currently placed in home facilities.

The Department is embarking on the adoption of a variety of therapeutic models beyond the D-rate, such as MTFC and ITFC. DCFS should analyze the implementation of the Wraparound Services process as to:

The percent of time used in early intervention with children in troubled homes
The percent of time used in transition from:
- – Foster homes to congregate-care facilities
- – Foster homes to reunification
- – Congregate-care facilities to reunification

In adopting the Wraparound Services model, the County should also keep in mind that Wraparound Services are not a program, but a process." ***Wraparound Services are effective for prevention, early intervention, ongoing intervention, and transitional planning.*** A national consensus outlined 10 requirements for successful Wraparound Care.

Wraparound Services are also effective for emancipated youth – children released from the system when they reach the age of 18. The goal should be for them to live independently, abide by the laws, and lead constructive lives in the community with minimal special support structures.

A critical component of Wraparound Services is to design plans that are comprehensive and therefore effective. Team members should be willing to use child and family resources in new and creative ways. They should move beyond conventional thinking to the use of their resources to support the youth and family. For example, during the last several years, the Five Acres "Expanding Circle of Care" has shifted its focus to provide more community-based services in addition to out-of-home care. In 2000, 531 families were provided these services as compared to 1,188 in 2006.

Out-of-home care consists of: foster care, congregate-care settings, residential treatment, and residential therapeutic school.

Community-based services include: family preservation, home-school based services, deaf services, Center for Survivors of domestic violence, therapeutic behavioral services, aftercare services, therapeutic day school, adoption promotion and support, multi-disciplinary assessment team, independent living, and Wraparound Services.

DCFS and Probation should embrace team decision-making, which would include all parties involved with the child (e.g., residential treatment staff, congregate-care staff). As a team, they should determine: who will be involved, what services are needed, who will provide the services, when the move will take place, and what are the needed connections to the new facility, school, and protocols for when children are placed with relatives.

The County should significantly expand both the numbers and levels of foster homes to ensure all dependents can be assigned to reside in a family environment that is able to cope with their needs. In addition to providing more effective care, it may prove to be more cost efficient.

Appropriate remuneration levels will be required to recruit, train, and retain classes of foster families and congregate-care facilities that can deliver these new models. Currently a small number of foster families are qualified to take D-rated dependents. They are paid an extra $ 535-$739 per month to care for these more difficult dependents. DCFS can also use the trained staff in successful residential-based facilities, where available, until such time that DCFS can provide training in these new categories.

Recommendation 3.2: DCFS, with involvement of Probation and the congregate-care facilities, should develop a plan to phase out facilities that do not meet quality assurance standards and are unable to provide the range of services needed by the dependents.

In the last five years, DCFS has tried to minimize the number of dependents who are maintained in congregate-care facilities. They agree that the old paradigm of 'warehousing' difficult adolescents and letting them age out of congregate-care facilities is inappropriate. DCFS should take this belief a step further and retain only those RBS oriented to:

Early permanent placement

Meeting all the service needs of the child, including the appropriate Wraparound Services to ensure successful transitions.

Research indicates that congregate-care placements are less preferred. During the site visits, the CGJ observed a number of effective operations, particularly residential-based facilities and multi-faceted agencies, which had talented staff, comprehensive services, and excellent results. Some small home facilities also had excellent living environments. These facilities should be retained, provided they meet the quality assurance standards and placement success goals, to be defined by DCFS.

As outlined by CWLA, the "Standards for Residential Care" should emphasize the importance of providing a range of support services for children and their families within a community context. Quality assurance standards should address "… critical policy and practice issues such as building family and community involvement; creating a safe and nurturing service environment; promoting positive child, youth, and family development; and ensuring culturally competent practices."[129]

Residential-based facilities have multi-faceted, specialized expertise which can be better used if DCFS works with them. DCFS should set up quality assurance audits to eliminate those congregate-care facilities that fall below a base level, and create a better awareness of the match between a dependent and the facility selected. On the basis of the CGJ site visits,

Free-standing, 6-10 bed home facilities appear appropriate for RCL-6 through RCL-10 children if they provide all the listed services and meet the standards being set up by DCFS.

Free-standing, 6-10 bed group facilities and residential-based facilities dealing with RCL-12 and above children require extended residential-based services with more structured, all-inclusive programs and more specific services to meet the needs of the children they serve, many of whom have extreme mental disturbances.

From CGJ's observations during site visits, the free-standing home-based facilities need to be affiliated with residential-based facilities or multi-faceted agency. The residential-based

[129] CWLA, the "Standards for Residential Care".

facilities, some originating as orphanages, appear to have transformed their services to meet the needs and requirements of the children entrusted to them. Their services encompass facility, staffing, program, school education, transition, community involvement, supervised activity, and enrichment activity; many of them have embarked on foster care services, adoption services, and training of foster care parents. Many have directly dealt with transition programs and emancipation issues by providing housing and employment under supervision prior to full emancipation.

As new categories of foster families become available, the reliance on congregate-care facilities can be reduced. One recommended strategy – new categories of foster families – is supported by best practices research[130]. Highly skilled and trained foster families can give the attention, unconditional love, acceptance, emotional support, encouragement, and continuity of values, and serve as consistent role models on a 24/7 basis which is key to positive child development. This type of placement is a less artificial environment than a group home facility and, as such, will result in an easier transition to a child's family or other placement options, such as adoption or guardianship.

Probation is not referenced in these recommendations primarily because they currently view congregate-care facilities as a more effective residential option than the camps. Probation should maintain close contact with DCFS during the implementation of this recommendation to ensure there is an orderly transition and that the appropriate supply of facilities is maintained to house their wards. In the longer term, Probation should assess the viability of special classes of foster families as a fourth residential option for their wards, classified as low risk.

Recommendation 4: The CEO needs to assist DCFS and Probation in developing a comprehensive and integrated information system.

Recommendation 4.1: DCFS and Probation should develop a comprehensive and integrated, automated information system containing all record and, reports that have been compiled on every child by all caregivers.

The current information systems need a major overhaul and modernization of its information technology (IT). The County needs a new system that can collect and track accurate child welfare and juvenile justice data and make it easy to track children, analyze progress, and assess outcomes. The Vista Del Mar Center appears to have good electronic medical records and IT system that track all aspects of a child's stay, including treatment and progress. This system would be worthwhile for the County to review as a potential prototype to consider.

Recommendation 4.2: The CEO should appoint an individual in charge of the implementation of this new and integrated system.

The CEO should identify an individual with responsibility to implement such a new information system that will integrate information systems across the involved County departments. Given the nature of this role, the incumbent should work closely with: a) the Chief Information Officer (CIO) of the County to ensure that the efforts are in alignment with the proposed County enterprise system, and b) the Information Technology Service (ITS) in the Internal Services Department (ISD), which maintains the current DCFS and Probation legacy systems.

[130] Best practices research is available in a supplement to the 2006-2007 CGJ Report.

Recommendation 4.3: The information in the DCFS and Probation systems should be partitioned to meet all current confidentiality requirements and should be easily linked to all other County systems to make additional, valuable information available for key decisions.

The County departments need a new information system for use by all involved professionals. That said, the system should assure that only those individuals who have the authority can access needed information. The system must respect the confidentiality concerns of the many professionals, such as the physicians, psychologists, psychiatrists, lawyers, CASAs, etc., who are part of the child's care. Access to key information should result in better placements and improved decision-making about the children. Over time, wherever possible, team decision-making should be encouraged with shared information to ensure optimal decisions for both the child and the system.

Researchers could be given access to all of the data by stripping or masking specific child identifiers.

Recommendation 4.4: The information should be available in a real time basis (24/7) to all professionals involved in the child's care subject to clearance (confidentiality) protocols established for each caregiver.

The appropriate tools (laptops, PDAs, connectivity etc.) must be provided to ensure real-time updating of the information and time sensitive access to the information by the various staff and professionals responsible for the children's care. The various congregate-care facilities should be part of the system as hubs that share DCFS and Probation data.

Recommendation 4.5: DCFS and Probation should conduct longitudinal studies on what happens to dependents and wards once they exit the system.

To measure results, follow up data needs to be collected on dependents and wards after they leave the system. Subjects may refuse to participate directly in interviews or surveys but incentives and indirect methods can be used to try to maintain enough data to support the type of evaluative research required. The County needs to provide the needed funding to provide such follow-up longitudinal reviews.

Recommendation 5: The CEO should immediately commission an organizational review to assess the CSW and DPO structure, staffing levels, and compensation.

From this CGJ investigation, the Departments had insufficient staffing and funding to care adequately for their dependents and wards. The staffing ratios of 50-55 wards per DPO in Probation and 30-35 dependents per CSW in DCFS speak for themselves. Average rates do not tell the whole story. Best practices recognize that a tiered approach linked to the type of case is optimal. In some types, a ratio of 4-8 cases per CSW may be appropriate. CWLA[131] recommends the following caseloads per social worker:

Initial assessment: 12 active cases per month

Ongoing case: 17 active families per month and no more than 1 new case for every 6 open cases

[131] CWLA Standards of Excellence for Services or Abused or Neglected Children and their Families, Revised 1999 (www.cwla.org).

Combined cases: 10 active on-going and 4 active investigations

Foster family care: 12-15 cases

Supervisors: 1 for every 5 social workers

Probation also has structural problems, which make it more difficult to fill current vacancies (25 DPO vacancies in March 2007). There are a variety of staffing models to evaluate, including staggered hours, work from home, and longer but fewer shifts that might attract more recruits to this position.

After the initial assessment, it is a 'best practice' to have the assigned CSW or DPO remain with the child throughout the child's stay in the system. Children who have multiple CSWs and DPOs tend to develop trust issues with adults and the system. Staffing, remuneration, and organizational supports should be set at levels that optimize the attainment of this continuity goal. The County should create a more highly skilled case manager position for the children with the most complex and difficult problems, such as those who are currently placed in an RCL-12 level or higher.

Realistic staffing levels should also be developed for the after-hours requirements of the DCFS Command Post.

Recommendation 6: In consultation with the congregate-care facilities' staff, DCFS and Probation management should develop and implement comprehensive assessment tools for making placement and exit decisions.

Poor initial placement decisions can often result in many changes of residence. This destabilization of the child's environment can have serious negative impacts, as statistically proven in this CGJ investigation. Other children exit the system without well-thought through transition plans or before they are ready.

Recommendation 6.1: DCFS should implement assessment centers in existing residential-based facilities that have the qualifications, capabilities, and capacity to provide such services.

The small amount of information available to CSWs for initial placement decisions is unacceptable. Both Departments have pilot projects where they are experimenting with more comprehensive assessments. Probation is using PACs to assess wards' educational, social, and emotional needs.

In those instances, where CSWs can complete the assessments, they should continue to do so. In other instances, the CSW may not have sufficient information; DCFS should establish assessment centers where dependents can be assigned until the initial assessments are completed and a thoughtful determination of the optimal placement can be made. A similar recommendation was outlined in the 1999-2000 Grand Jury Report; at that time, DCFS agreed with the assessment center in concept but lacked the funding to establish such centers. This CGJ recommends that DCFS establish assessment centers within some of the existing comprehensive residential-based facilities, which should be easier to implement immediately and prove to be cost-effective. The assessments should involve multi-disciplinary teams. In this way, a dependent could be assessed and an appropriate placement found without the pressures of placing a child in a crisis mode.

Recommendation 6.2: The CSWs and DPOs should furnish the courts with the initial assessment reports and their updates should include input from the facilities regarding their dependents and wards respectively.

DCFS and Probation should furnish comprehensive initial assessments for their charges when the courts are making placement decisions. When children require changes in placements, the Departments –with input from the facilities – should again submit updated reports.

Recommendation 6.3: As part of the assessment process, DCFS and Probation should set goals, measure the effectiveness of their placements, and identify causes for ineffective placements or outcomes.

Both DCFS and Probation should set goals to minimize the number of placements for each child and actively evaluate and improve their success rates. The Departments should do more empirical research in the area of placement effects: Why do congregate-care placements increase the risk of offending? Why do the increased number of placements result in decreased educational outcomes? How can the Departments learn more about congregate-care facilities in the interest of providing evidenced-based services? ***There are currently too many hypotheses, and not enough quantitative analysis, about these issues and other issues. The County must move from theory to evidence-based practices with quality assurance reviews and data analysis.*** Moving children to another placement setting and not to understand why these problems emerge is short-sighted. Many of these children are in congregate-care placements because there are no family-based placements available for them. These assessment approaches should be evaluated and, if effective, brought into regular use by a designated deadline.

Recommendation 6.4: DCFS and Probation should assess and develop new strategies for their respective AWOL dependents and wards.

The County may have as many as 450-500 AWOL children at any given time. If a dependent or ward goes AWOL, their "beds" are reassigned after three days. AWOL dependents typically do not attempt to return; and not all CSWs aggressively try to locate them. In the case of wards, if they return, Probation arrests them and sends to either a Probation camp or a Department of Juvenile Justice facility (State-operated) for more serious crimes.

Both Departments should assess what factors increase the predictability that particular dependents or wards will go AWOL and develop strategies to mitigate these factors.

Recommendation 6.5: The assessment process should include an evaluation of a child's readiness to exit the system and outline a methodical transition plan with receptivity to creative solutions.

DCFS and Probation should avoid arbitrary timelines, such as: a) a ward's probationary period ends but the ward is just shy of completing his/her high school diploma, or b) DCFS's vague criteria to determine when a dependent child is ready for a less restrictive environment. In many instances, children leave the system prematurely, before their situations have stabilized. Length of stay was mentioned at DCFS and Probation sites as an issue in terms of the efficacy for modifying behaviors, changing attitudes, and providing therapy for troubled children.

Therefore, DCFS and Probation should develop transition plans in collaboration with the congregate-care facilities. The County might consider the Transition Guardian Plan approach where support and a stipend are provided to foster self-sufficiency, as developed at the

University of San Diego School of Law's report, "Expanding Transitional Services for Emancipated Foster Youth: An Investment in California's Future."

The County should consider the best practices already occurring in greater Los Angeles. Some congregate-care facilities assist their emancipated youth in making the transition by providing transitional housing. For example, Boys Republic in Chino Hills and Rancho San Antonio in Chatsworth return the rent collected when the emancipated youth is ready to leave. This rent refund helps them in their quest for independence by providing a rental deposit and initial funds. As another example, Hillside Home for Children in Pasadena purchased a larger apartment building and uses the rental income from the other apartments to subsidize the rent for the emancipated youth. Others purchased property to provide low rent and helped emancipated youth to find work in the community.

The County should start a program for hiring qualified emancipated youth, dependents, or wards in County jobs. Such a program was implemented for a while in the Internal Services Department for craft positions.

Staffing, funding, and other required resources to accomplish the new comprehensive assessment program and transitional strategies should be included in the organizational review, discussed in Recommendation 5.

Recommendation 7: DCFS, Probation, and the ECC should develop strategies that ensure that their dependents and wards achieve education levels at or above their age groups.

Many children come into the child welfare and juvenile justice systems at below grade level for their age because of their life situations. Educational achievement is key to the child's future success, and can contribute to a sense of competency and well-being while in the system. A variety of strategies should be undertaken to ensure the child's success at school.

- Each child should have a timely and comprehensive educational assessment prior to school transfer and, if necessary, an IEP. These tools should be used to determine what extra help will be provided, such as tutors, extra class help, homework assistance, etc., to help the child achieve or exceed his/her grade level.
- All efforts should be made to help children complete their commitments to complete their school term or graduation requirements. DCFS and Probation should not transfer a child to a different placement until after the end of the school term or year.
- DCFS and Probation should establish outcome measures (discussed in Recommendation 2), such as high school graduation rates, pursuit of postsecondary education or vocational certificates, etc.

Educational gains are possible. At Five Acres, its K-8 day school has a capacity of 80 slots, and 30 children from the community attend. The largest class is 12 students and its overall ratio is 1 to 4. Summary data for a period of two years indicated that, at the time of admissions, students averaged .65 grade levels of achievement per year of school attendance. This increased to an

average of 1.0 grade levels per year, as measured by the annual school achievement (Woodcock-Johnson) testing results.[132]

In several site visits, the CGJ encountered youth in small, community-based facilities who were fearful of going to school (public school) outside of the facility because of previous gang involvement. Consideration of location should be taken into account in placement decisions. One facility, Children Are Our Future, bused children to different public schools to mitigate this issue.

The County can help children access more enrichment activities in residential-based facilities and community group facilities by extending all discounts for amusement parks and other events afforded to County employees.

Recommendation 8: The CEO should ensure that DCFS and Probation's current practice of assigning dependents and wards to the same facilities ceases immediately.

This CGJ investigation has discussed the potentially adverse impact of congregate-care facilities on children's increased propensity to commit crimes. According to senior officials in both Departments, separation of dependents and wards will provide more appropriate environments for the children.

This recommendation will cause disruption, particularly for group home facilities. Some of the excess capacity may be taken up by Probation. Some capital support may be required to help congregate-care facilities accommodate the shift to being an all-Probation or all-DCFS group facility. But nevertheless, dependents and wards should be served in different facilities.

Recommendation 9: DCFS and Probation should strategically use congregate care facilities that meet quality assurance standards and provide awards for achieving meaningful outcomes.

DCFS and Probation should retain its relationships with the high-quality, congregate-care facilities that they currently have, as long as those settings meet quality assurance standards and are the least restrictive for specific dependents and wards to thrive.

Other congregate-care facilities should be phased out – either because of the poor quality or because of reduced demand for their services with the new treatment models to be implemented. The transition may take 2 to 5 years. During this period, there will be disruptions, spare capacity, and other operating problems. To ensure that congregate-care performance does not deteriorate over this period, the Board should consider extra funding support.

Recommendation 9.1: DCFS and Probation should study how best to improve group home facilities' programs, staffing skills and staffing levels.

The State payment levels have not been adjusted since 2001, despite inflation over this period. Senior officials of both Departments believe the current funding levels result in low wages, minimum qualifications, limited training, and high turnover of congregate-care staff.

[132] Five Acres Non Public School (NPS) Program Annual Program Review. Five Acres Research Department, September 2006.

Recommendation 9.2: Probation and DCFS should find ways of rewarding and acknowledging those congregate-care facilities that obtain exceptional results with dependents who age out, emancipate, are permanently placed, or reunited with their families.

When dependents are moved back to their original environment from congregate-care facilities, gains and accomplishments are frequently lost. Many of the children lack family support or safety networks when they reach age 18. In addition, the dependent status is a stigma; for wards who have turned their lives around, their juvenile record is a barrier to gainful employment.

During the CGJ's investigations, many well-run, congregate-care facilities, particularly multi-faceted, residential-based facilities that had campus-like settings, had more than successfully provided for their charges and had become surrogate parents on a life-time basis. Rancho San Antonio has a model transition program for wards.

The goal is to: a) encourage more congregate-care facilities to go the extra mile and adequately prepare dependents for any transition, and b) ensure that appropriate programs are in place if the dependents are going out on their own. This goal will require coordination with Wraparound Services agencies to ensure that all parties are prepared for the transition. Transitional funding needs to be coordinated with Wraparound Services funding so there is not a decrease in the overall reimbursement during these endeavors.

Recommendation 10: DCFS and Probation should meet at least annually with congregate-care providers to share best practices.

DCFS and Probation should establish their own separate annual or semi-annual meetings with all congregate-care providers to exchange best practices, share successful outcomes, act as an educational forum, and deal with common issues. Awards can be given out to: a) successful outcomes at congregate-care facilities and b) DCFS and Probation employees who have made extra efforts to transform children's lives. ***County recognition of special efforts and ideas would go a long way with those that do provide exceptional service and make super efforts on behalf of the children.***

DCFS and Probation management should communicate with each other and share the results, information, and recommendations formulated during these conferences. DCFS also needs to establish ***better, consistent, and scheduled*** communication with providers.

Recommendation 11: The CEO should establish an inter-departmental task force charged with implementing these recommendations and the shift outlined in its Foundation white paper.

Well-intentioned managers and professionals currently have good ideas and intensions, which often do not get implemented because those involved are too busy with their day-to-day duties to carry out the intense work of creating real change in the system. DCFS, Probation, and DMH should create an interdepartmental task force whose sole responsibility is to develop and launch these recommendations and other new child-focused programs. This task force should also collect and analyze factors related to resilience and educational success of former youth in congregate care facilities. If the system is to be effective in its role as a custodian for wards and dependents, it needs to move beyond correcting deficiencies to a focus on systematically nurturing the strengths and talents of those children served by Los Angeles County. This task

force would enable a group of experienced, dedicated people to focus all of their attention on shifting the child welfare system in Los Angeles County to the new model.

VII – CONCLUSIONS

DCFS, Probation Department, and congregate-care facility staff members are hard-working and dedicated to the well-being of the children in their charge. The number of children who annually enter the child welfare and juvenile justice systems is staggering. Many are victims of unfortunate family or environmental situations. Each of these young lives is precious. More must be done to ensure these assets do not become community liabilities.

Even more disappointing is the estimate by Probation officials that 40% of the wards that enter their system were once dependents in the child welfare system. This is a poor outcome, given the dedication and hard work of all involved. It draws into question the efficacy of the County's current programs and methods of care for these children.

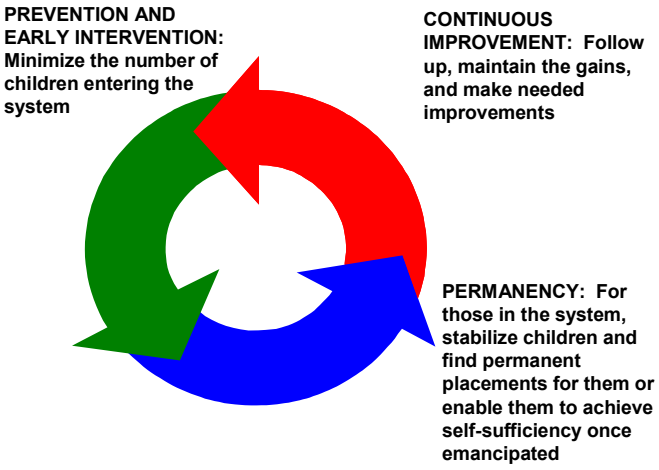
Regardless of one's parenting philosophy or views on the relative responsibility of the child for his/her actions, most agree these children are at great disadvantage mainly because of circumstances largely beyond their control (family, environmental, educational, or mental health). While some may be lost, most children have remarkable resiliency if given the right nurturing.

The County can make a difference in their life trajectory in three ways:

Prevention and Early Intervention – Intervene early to minimize the number of children who enter the system

Permanency – Provide exemplary programs that stabilize the children, help them learn and thrive, and get them permanently placed or prepared for emancipation

Continuous Improvement – Provide follow-up services to maintain and enhance the gains



On the basis of these findings, DCFS and Probation have some key opportunities to address to improve the current system:

Introduce prevention and early intervention initiatives and measures that will reduce the number of children that enter the system each year

Focus the system to measure both the on-going activities and also the actual long-term impact these activities and programs are having on the life trajectories of the children; use data, trends, and outcomes to make empirically based decisions

Improve the staffing, information systems, and information sharing across County departments involved in health and social support services (i.e., DCFS, Probation, Department of Health Services (DHS), and Department of Public Social Services (DPSS) and with congregate-care facilities

Phase out over time congregate-care facilities that are not providing full services, ensure that children (particularly dependents) placed in group home facilities can benefit from such a setting as the least restrictive environment for them; and maintain and improve the programming and effectiveness of congregate-care services during the transition

Develop stronger and integrated communication mechanisms across the system, which will not only improve efficiency but effectiveness of serving children

Collaborate more with the schools to ensure that children can complete their school terms, earn high school diplomas, and have complete, implemented, monitored, and updated IEPs

Focus on the total needs of the child – emotional, social, educational, and mental

Reduce the DCFS and Probation caseloads

APPENDIX A – ACRONYMS

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ACHSA	Association of County Human Services Agencies
ADHD	Attention-Deficit/Hyperactivity Disorder
AWOL	Away Without Leave
CAP	Corrective Action Plan
CASA	Court-Appointed Special Advocate
CCF	Congregate-Care Facility
CCL	Community Care Licensing (State of California)
CCS	California Children's Services
CDSS	California Department of Social Services
CEO	Chief Executive Officer
CGJ	Civil Grand Jury
CIO	Chief Information Officer
CSW	Children Social Worker
CWLA	Child Welfare League of America
DCFS	Department of Children and Family Services
DHHS	U.S. Department of Health and Human Services
DHS	Department of Health Services
DMH	Department of Mental Health
DPO	Deputy Probation Officer
DPSS	Department of Public Social Services
ECC	Education Coordinating Council
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Response
FCARL	Foster Care Audits and Rates Letter
FFA	Foster Family Agency
FM/R	Family Maintenance & Reunification
GF	Group Facility
HOP	Home on Probation
IEP	Individual Educational Plan
ISD	Internal Services Department
IT	Information Technology
ITS	Information Technology Service
ITrack	Incident Tracking System
ITFC	Intensive Treatment Foster Care
LACO	Los Angeles County
LAUSD	Los Angeles Unified School District
MOU	Memorandum of Understanding
MST	Multisystemic Therapy
MTFC	Multidimensional Treatment Foster Care
NPS	Non-Public Schools
NREFM	Non-related Extended Family Member
OHC	Out of Home Care
PAC	Placement Assessment Center
PI	Prevention Initiative
PUSD	Pasadena Unified School District
P3	Permanency Partners Program
RBF	Residential-Based Facility
RBS	Residential-Based Services
RCL	Rate Classification Level
SCSW	Supervising Children's Social Worker
SIB	Service Integration Board
SIR	Special Incident Report
SPA	Service Provider Area[133]
SW	Social Worker
TA	Technical Assistant
TAY	Transition Age Youth
TDM	Team Decision Making
TFC	Therapeutic Foster Care

[133] SPAs are regional centers in the County of Los Angeles, designed to provide a variety of social services from a single, regional location.

APPENDIX B – QUANTITATIVE FACT-FINDING AND ANALYSIS

COUNTY DATA SOURCES

Several sources of data are used in the current report, which include administrative records for all children and families involved with DCFS and the Probation Department in Los Angeles County.

DCFS Records

The child welfare data (DCFS) includes demographic information (birthdates, race, gender); allegations of maltreatment (report date, type of maltreatment, finding); and child welfare services (placement dates, placement types). The measure of maltreatment includes official reports of physical abuse, sexual abuse, neglect, emotional abuse, and substance exposure at birth.

The child welfare records include all youth (n=91,860) involved[134] with DCFS between 2002 and 2005. Such cases may be limited to a single maltreatment allegation, but also include children receiving in-home services and children in long-term placements. This investigation focuses on the effects of Group Home placements – so the analyses are limited to youth with at least one out-of-home placement.

The sample changes slightly between research questions:

Question 1 (comparison of Group Home and non-Group Home youth) – the sample includes any youth with at least one episode in out-of-home care (n=53,095).

Question 2 (Group Home placement and the likelihood of delinquency) – the sample is limited to adolescents between ages 7 and 16 so that each youth is eligible for a delinquency petition during the period of observation (2002 – 2005) (n=20,309).

Question 3 (Group Home placement and the likelihood of family reunification) – the sample includes any youth with at least one episode in out-of-home care and a case closure by December 31, 2005 (n=32,197).

[134] Involvement with child welfare in Los Angeles County includes any open or ongoing case between 2002 and 2005.

Probation Records

The delinquency records originate with the Los Angeles County Probation Department and include all arrests (n=230,259) for all minors (n=82,376) in Los Angeles County between 2002 and 2005. The delinquency records include demographic characteristics (birthdates, race, gender), arrest date, offense type, and judicial disposition. The child welfare and juvenile justice records do not share a common unique identifier (e.g., social security number). To address the questions, the files had to be merged, using probabilistic software that matches administrative records by common identifiers (last name, first name, birth date, race, gender).

Individual Characteristics: The first research question focuses on comparing Group Home and youth in other placement settings, using DCFS records on age at placement, sex, race, placement instability (i.e., number of changes in placement), length of case opening, and maltreatment history (e.g., records of physical abuse vs. neglect).

Delinquency Measure: There is no single ideal measure of delinquency. Within the maltreatment – delinquency literature, researchers have used a variety of measurement techniques including self-report surveys, official arrest records, entry into secure correctional settings, and even the transition to probation (Thornberry & Krohn, 2000; Widom, 1991; Jonson-Reid, 2002; Ryan & Testa, 2004; Ryan, in press). There are advantages and disadvantages associated with each approach. For example, self-report surveys have the ability to capture offending behaviors that are unknown to law enforcement. Yet such surveys are also susceptible to respondent bias. Therefore, in this investigation, the official arrest data provided by the County's Probation Department was used. This measurement of delinquency is broad and includes any arrest ranging from minor probation violations to murder. Status offenses and traffic violations are not included.

Measures of Family Reunification and Permanence: The DCFS administrative records have a field that captures current living situation and reason for case closure, which were useful fields to estimate and compare rates of family reunification for individuals with at least one Group Home placement versus no Group Home placements (but with at

least one out of home placement). The likelihood of permanence and adoption were also estimated. The term permanence refers to stable placements achieved via family reunification, adoption, or guardianship.

PRELIMINARY ANALYTIC TECHNIQUES

Social scientists frequently encounter data that include a limited number of "treatment" cases and a generally larger number of comparison cases. For example, in this investigation, the County database had approximately 6,400 adolescents with at least one Group Home placement between 2002 and 2005. In contrast, the County had approximately 47,000 adolescents in other placement settings during the same period. A variety of methods are available to control for initial differences (selection effect) to compare these two potentially distinct set of individuals. For this investigation, Propensity Score Matching (PSM) procedures were initially applied to minimize bias and test whether Group Home placements were associated with delinquency and family reunification. Matching is a technique used to select control subjects (non-Group Home youth) who are "matched" with the treated subjects (Group Home youth) on background covariates.[135] Even though the notion of finding matches appears to be straightforward, it is often difficult to find individuals that are similar across a variety of key covariates, even when there are only a few background covariates of interest (Rubin, 1976). PSM solves this issue by letting researchers control for many background covariates simultaneously by matching on a single scalar variable (D'Agostino, 1998).

The PSM outcome was approximately 3,500 matches. When the PSM models were run against other non-matched regression models to test for model improvement, the pattern of effects was identical. Given the loss of approximately 3,000 youth in the matching procedures – and the results did not change – this investigation developed and presented regression models without a matched sample.

ESTIMATING GROUP HOME EFFECTS

Maltreatment – delinquency often identifies the increased risk associated with Group Home placements. Yet prior research has yet to pinpoint the exact timing of the delinquent event in relation to the Group Home placement. That is, are Group Home youth more likely to offend subsequent to their placement? If so, one might argue that it is not the group placement *per se* that is increasing the risk but rather the placement destination for a Group Home youth relative to a youth leaving non-congregate care placements. In this investigation, three different strategies were used to estimate the association between Group Home placement and delinquency:

- A variety of Cox Regression models to focus on the size and direction of the coefficient associate with Group Home placement. This strategy is consistent with prior research and estimates the risk of subsequent delinquency for any youth with at least one Group Home placement.
- The arrest dates and placement dates (intake and discharge) are used to identify the specific placement at the time of the initial arrest. This is important because it is unclear where youth reside within the child welfare system at the time of arrest. For example, are youth arrested and then moved to a Group Home placement or does delinquency emerge during the actual Group Home placement?
- Comparisons of the types of offenses committed by youth in various placement settings are compared. This strategy addresses whether Group Home youth are qualitatively different with regard to the types of offenses committed.

DISENTANGLING THE EFFECTS OF FREQUENT INSTABILITY FROM TYPE OF INSTABILITY

Placement refers to the physical location of a child. If a child moves from foster care to a Group Home, this constitutes two placements. In contrast, spells refer to a continuous episode of substitute care placement, regardless of how often children move between physical locations. In the example provided, the movement from

[135] The PSM analysis was performed with STATA/PSMATCH2. The method selected was nearest neighbor matching within caliper with no replacement. This method consists of randomly ordering the treated (Group Home) and control (youth in other placement settings) subjects, then selecting the first treated subject and finding the control subject with the closest propensity score within a predetermined common-support region called a caliper. Both subjects are then removed from consideration for matching and the next treated subject is selected.

There are several choices in terms of selecting the caliper size used. One choice suggested by Guo, Barth, and Gibbons (2006) is to use a narrow or more restrictive caliper size of 0.1. If the result is a smaller sample than desired, the sample size can be increased by increasing the caliper size following the Rosenbaum and Rubin (1984) suggestion of setting the caliper size to a quarter of one standard deviation of the explanatory variable. This investigation tried both methods. Each method produced the same results.

foster care to Group Home represents two placements but one spell. This investigation calculates placement instability by summing the number of changes in the physical location of substitute care, and assesses the association between placement instability and the risk of delinquency.

The placement instability literature focuses almost exclusively on frequent movements youth experience within the child welfare system and the negative outcomes associated with such movements. In contrast, this investigation is different because it focuses on determining whether delinquency is associated with the frequency of movements or the reasons associated with each movement. The County's DCFS administrative files include a description of each placement change. This investigation paid particular attention to placement disruptions that result from running away (AWOL) and for reasons associated with child behavioral issues (problems other than delinquency).[136] This analysis also includes an overall measure of instability (number of placement changes). Within the regression analyses, we do not continue to count changes in placement (even within the same placement spell) once a delinquent event occurs. This strategy avoids confusing placement instability that results from delinquency as opposed to delinquency that results from placement instability.

FINAL ANALYTIC TECHNIQUES

The following analytical techniques were applied:

Question 1: T-tests, cross-tabulation, and chi-square were used to test for differences between Group Home and non Group Home youth.

Questions 2 and 3: Cross-tabulation and chi-square statistics explored the relationship between Group Home status, delinquency, and family reunification.

Survival analysis (SPSS Cox Regression v.14) was used to examine the influence of individual variables on survival rates. This analytic technique is similar to logistic regression in that it calculates the odds of a particular event occurring. Survival analysis, however, considers the differential impact between groups on the timing of this event (Land, McCall & Parker, 1994).

In this investigation, youth enter the observation period (2002 – 2005) at different points in time. For example, a youth may be 8 years of age in 2002. In general, children younger than 9 years of age are not processed in the juvenile justice system. Thus, the 8-year-old is only at risk of delinquency for approximately three years (2003 – 2005). In contrast, an adolescent that is 10- years-old in 2002 is at risk for the entire observation period. In short, individuals are exposed to the risk of delinquency for varying lengths of time. The average time at risk in the current study is 1,384 days (3.7 years). The sample was selected so that all youth are at risk for at least one year.[137] For questions related to reunification and permanence, logistic regression was applied because the sample includes only those youth with a closed case.

As part of our analytic strategy, a variety of race and gender interaction terms were also analyzed. Minority overrepresentation is an issue of great concern for child welfare and juvenile justice systems (Testa & Poertner, 2003; Snyder, 2000; Hsia, Bridges, & McHale, 2004). Within the child welfare system, African-Americans are more likely to be investigated for maltreatment, have a child placed in foster care, and spend more time in foster care, and are less likely to achieve family reunification (Courtney & Skyles, 2003). Within the context of the juvenile justice system, African-American youth are more likely to be arrested and placed in detention, and less likely to receive mental health services (Leiber & Fox, 2005; Rawal, Romansky, Jenuwine & Lyons, 2004). Similarly, there is a broad literature describing gender differences. Females under age 18 represent the fastest growing segment of the juvenile justice population; their arrests having increased by 72% since 1983 as compared to 30% for males (Snyder, 2002). Females are also more likely to be held for technical violations and status offense in the juvenile justice system (Sickmund, 2004). Despite these trends, when the County data were tested specifically for potential subgroup differences, no significant race or gender interactions emerged, so these terms were removed from the final models.

[136] The DCFS reference category includes placement changes that result from a transition to a less secure environment, placement with siblings, and foster family relocation.

[137] Survival models adjust for these variations by censoring observations. Observations are censored if the target event (delinquency) is not observed during the observation period. The resultant coefficients are interpreted similarly to those from logistic regression.

APPENDIX C – GROUP HOME QUANTITATIVE FINDINGS

Results for Question 1: How do Group Home youth compare with youth placed in other out-of-home placement settings?

The purpose of these analyses is to understand the differences between the populations served in Group Homes and other out-of-home placement settings. On the basis of prior studies (included within the literature review), differences to emerge between the two placement groups were anticipated. The sample includes youth with at least one episode in out-of-home placement that lasted at least two weeks in duration (n=53,095). Within this sample, 6,422 (12%) youth had at least one Group Home placement. Analyses are limited to the fields that are available within the DCFS administrative records. Such fields include age at placement, race, gender, reason for removal, number of placement changes (i.e., placement instability), and length of case opening. As expected, significant differences emerge on almost every characteristic:

Youth in Group Home placements are:

Significantly older (13.3 years vs. 6.7 years, $p<.01$)

More likely to be African-American (47% vs. 39%, $X^2 = 298.12$, $p<.01$)

More likely to be male (56% vs. 48%, $X^2 = 125.10$, $p<.01$)

Regarding the reason for placement, youth in Group Homes are less likely to have a history of general neglect (21% vs. 33%) but more likely to: have a history of:

Physical abuse (15% vs. 10%)

Caretaker absence (33%, 26%, $X^2 = 531.10$, $p<.01$)

Regarding placement instability, youth in Group Homes experience significantly more changes in placement (8.1 vs. 3.0, $p<.01$).

Regarding case duration, the cases for youth in Group Home placements remain open for significantly longer periods of time (6.2 years vs. 4.4 years, $p<.01$).

Results for Question 2: What is the profile of juvenile offenders?

The sample (n=20,309) is 43% African-American, 40%% Hispanic, 15% White, and 2% Asian. On average, children were 8.8 years old at the time of their first placement; 48% of the sample is male. With regard to placement type, 71% had at least one placement in foster care, 53% had at least one placement in a relative care home, and 23% had at least one placement in a Group Home. With regard to instability, 49% of the youth experienced at least three different placements. Approximately 9% of the youth experienced a change in placement due to running away (AWOL) and approximately 7% experienced a change in placement due to child behavioral problems. On average children stayed in care a total of 46 months. With regard to delinquency, 2,106 (10.4%) of 20,309 adolescents in placement had at least one arrest subsequent to their first placement episode.

RISK OF DELINQUENCY

The results from the bivariate analyses are displayed in Table C-1. Consistent with prior studies and the overall risk of delinquency in the general population:

Males in the County child welfare system are more likely to engage in delinquency as compared with females in the child welfare system (14% vs. 7%)

African-Americans had the highest risk of delinquency (13%) as compared with Hispanics (9%), Whites (8%), and Asians (5%)

The risk of delinquency was significantly lower for placements associated with neglect (9%) as compared with placements associated with physical abuse (12%), sexual abuse (13%), and emotional abuse (14%)

With regard to placement instability, ***adolescents with four or more placements were more likely to experience delinquency relative to adolescents with three or fewer placements (16% vs. 7%).*** The reasons for instability also appear to impact the likelihood of delinquency. Movements associated with AWOLs (30% vs. 9%) and child behavioral problems (24% vs. 9%) increase the likelihood of delinquency. With regard to Group Home placements, ***adolescents with at least one Group Home placement are at an increased risk of delinquency (22% vs. 7%).***

Table C-1: Bivariate Results: Child and Placement Characteristics and Delinquency (n=20,309)

	Not Delinquent	Delinquent
Race**		
African-American	87%	**13%**
Hispanic	91%	**9%**
White	92%	**8%**
Asian	95%	**5%**
Sex**		
Female	93%	**7%**
Male	86%	**14%**
Type of Maltreatment*		
Physical abuse	88%	**12%**
Neglect	91%	**9%**
Emotional abuse	86%	**14%**
Sexual abuse	87%	**13%**
Placement Type**		
Foster care	89%	**11%**
Relative foster care	89%	**11%**
Group home	78%	**22%**
Placement Instability**		
Only one placement	93%	**7%**
Two placements	93%	**7%**
Three placements	92%	**8%**
Four or more placements	84%	**16%**
Type (Reason) of Placement Instability**		
AWOL	70%	**30%**

	Not Delinquent	Delinquent
Child behavioral problems	76%	**24%**

	Mean	**Mean**
Age at first placement **	8.8	**9.2**
Length of time in all substitute care placements (months)**	44.9	**56.9**
Length of time in group home placements** (months)	5.0	**11.8**

TYPE OF DELINQUENT OFFENDING

Of the 2,106 youth with at least one delinquency offense, 24% were associated with a violent offense, 17% burglary, 5% weapons, 5% terrorist threats (i.e. threats of physical violence), 4% drugs, and 3% sex related.

SURVIVAL ANALYSIS

Table C-2 includes the coefficient and standard error for each independent variable and the hazard ratio from the Cox regression analysis. A hazard ratio greater than 1 indicates a higher likelihood of delinquency. A hazard ratio less than 1 indicates a lower likelihood of delinquency. If 1 is subtracted from the hazard ratio and the remainder is multiplied by 100, the resultant is equal to the percent change in the hazard of achieving family reunification. Of the 20,309 adolescents, 2,106 (10.4%) were arrested at least one time subsequent to the start of their first placement. The Cox regression model was developed in four separate steps:

1. A variety of demographic information were entered.
2. A dummy variable indicating group home placement (0 = no group home placements, 1 = group home placement) was entered.
3. Measures of placement instability were represented with three dummy variables indicating two placements, three placements, and four or more placements. The reference group is youth with only one placement.
4. Two variables indicated the various reasons for placement instability. The first variable refers to instability associated with an AWOL and the second refers to instability associated with child behavioral problems.

Table C-2: Cox Regression: Delinquency for Adolescents in Child Welfare Placements (n=20,309)

	Model 1			Model 2			Model 3			Model 4		
	B	S.E.	Exp (B)	B	S.E.	Exp (B)	B	S.E.	Exp (B)	B	S.E.	**Exp (B)**
Age	.04*	.01	1.04	.03*	.01	1.03	.04*	.01	1.04	.03*	.01	**1.03**
African-American	.55*	.07	1.73	.59*	.07	1.80	.60*	.07	1.81	.57*	.07	**1.78**

	Model 1			Model 2			Model 3			Model 4		
Hispanic	.06	.07	1.06	.19*	.07	1.20	.18*	.07	1.20	.16**	.07	**1.17**
Asian	-.54**	.24	0.58	-.42	.25	0.67	-.40	.25	0.67	-.46	.25	**0.63**
Male	.68*	.05	1.97	.59*	.05	1.80	.61*	.05	1.84	.72*	.05	**2.05**
Neglect placement	-.20*	.05	0.82	-.11*	.05	0.89	-.12*	.05	0.89	-.10**	.05	**0.90**
Group home placement				1.16*	.04	3.17	.96*	.05	2.62	.77*	.06	**2.17**
2 placements							-.07	.08	0.94	-.08	.07	**0.92**
3 placements							-.07	.08	0.94	-.10	.08	**0.90**
4 + placements							.34*	.07	1.41	.13	.07	**1.14**
AWOL move										1.08*	.06	**2.94**
Child behavior move										**.39***	**.06**	**1.48**

*p<.05, **p<.01

The results of the Cox regression are similar to those reported in the bivariate tables. Gender, group home status, and AWOLs have the biggest impact on subsequent delinquency. In the final model, the relative risk of delinquency is approximately two times greater (Exp(b) = 2.05) for males as compared with females in substitute care placements. The relative risk of delinquency is more than two times greater (Exp (b) = 2.17) for adolescents with group home placements and approximately three times greater (Exp(b)=2.94) for adolescents with a history of running away (AWOL). Similar to prior studies of maltreatment and delinquency, African-American, and Hispanic adolescents experience an increased risk of delinquency relative to White adolescents. There is no difference with regard to relative risk when comparing White and Asian youth. With regard to placement instability, it is important to note the changes between model three and model four. In model three, the risk of delinquency appears to increase for adolescents with four or more changes in placement; however, once controlled for type of instability (i.e., reasons children changed placement), the overall instability effect disappears. ***Thus, it may not be instability itself that is responsible for an increased risk of delinquency but rather the circumstances associated with particular changes in placement.*** In the final model, the reference category for type of instability is placement changes due to the relocation of foster parents, placement with siblings, and moving adolescents into less secure environments.

The results of the Cox regression models indicate that adolescents with at least one group home placement are more likely to engage in delinquency relative to adolescents with no group home placements. But at what point are these youth arrested? Are these adolescents arrested during their stay in the group home or subsequent to their release? The data in Table C-3 indicate that ***the majority of arrests occur while youth are in placement or on the run from placement.*** Of the 2,106 adolescents with at least one arrest, 1,671 (79%) of these youth experienced their first arrest in a substitute care placement setting. Of the 1,671 adolescents arrested in placement, 675 (32%) occurred while the youth was placed in a group home. Only 23% enter group home placements and, perhaps more importantly, ***little time (relative to the total time in out-of-home care) is spent in group home placement (on average 5.5 months). Yet the group home is where approximately one-third of all arrests occur.*** Adolescents are far more likely to enter foster care (relative or non-relative) and spend far more time in foster care, yet the percentage of youth arrested in these placements is significantly less than that associated with group home. The timing of arrests is an important distinction as it addresses whether there is a lingering group home effect or whether the experiences and impact of the group home are more immediate. Adolescents slowly adopting values and beliefs consistent with deviant lifestyles and then

acting upon those beliefs subsequent to their release from the group home might be indicative of a lingering or sleeper effect. Yet the adolescents in the current study are arrested during their group home placement – perhaps indicating that the effect of these placements is more immediate.

Table C-3: Placement Location at Time of Initial Arrest (n=1,671)

Location at Time of Initial Arrest	Number	%
Group Home	615	**37%**
Relative foster care	491	**29%**
Non-relative foster care	466	**28%**
AWOL (run away from placement)	70	**4%**
On home trial visit	17	**1%**
Shelter	12	**1%**
Total	1,671	100%

So group home placements appear to increase the risk of delinquency. This is evident by the estimates generated in the Cox regression models and a more detailed descriptive analysis of the location of each youth at the time of initial arrest. But a question remains with regard to the types of offenses committed by youth in various placement settings. If the research on congregate care effects is accurate (citation related to harmful interventions and peer group effects on socialization), one would expect to see differences with regards to specific offending behaviors. For Los Angeles County, the offense types for adolescents in group homes, non-relative foster homes, and relative foster homes were compared across five broad categories of offending; the categories are similar to those used by the Federal government (OJJDP, 2004) are constructed and compared. These categories include property,[138] violence,[139] threats, drug and weapon-related offenses. Three significant differences emerge:

Adolescents in group homes are significantly less likely to engage in burglary (13%) as compared with adolescents in non-relative foster homes (18%) and relative foster homes (20%).

Adolescents in group homes are significantly more likely to engage in terrorist threats (9%) as compared with adolescents in non-relative foster homes (5%) and relative foster homes (5%).

Adolescents in group homes are significantly more likely to engage in violent offenses (38%) as compared with adolescents in non-relative foster homes (21%) and relative foster homes (20%).

Moreover, the percent of violence-related offenses are greater than the percent reported within the general delinquency population. In 2003, approximately 2.2 million minors were arrested. Of these arrests, approximately 335,000 (15%) were violence related.

[138] The property offenses include burglary, larceny-theft, motor vehicle theft, and arson.
[139] The violent-related offenses include murder and non-negligent manslaughter, forcible rape, robbery, aggravated assault, and other assault.

Results for Question 3: What is the relationship between group home placement and permanency outcomes?

These analyses are limited to the placement cases that closed in Los Angeles County between 2002 and 2005 (n=32,197), using three identical logistic regression models – exchanging the outcome variable of interest. The models were built in three steps to best understand the relationship between group home placements and each outcome: family reunification, permanency, and adoption.

1. Each model includes only group home status, which permits analysis of the relationship between group home status and the outcome of interest – without additional covariates in the model.
2. Child demographics – age at placement, African-American, Hispanic, Asian, gender, and neglect – were added to each model. The reference groups are White, female, and physical and sexual abuse.
3. Each model includes measurement of placement instability (e.g., two changes in placement, three changes in placement). The reference group for the measurement of placement instability is one placement – that is, the group of individuals with only one out-of-home placement.

Group home status is a significant predictor in two of the models.[140] With regard to the reunification model, group home status is a significant predictor in the first step of the regression – the step with no other covariates in the model. The Exp(b) = .85 which translates into a 15% decrease in the odds of achieving reunification. In the two subsequent models (step 2 and step 3 in Table C-4), however, the group home effect disappears. That is, the effect apparently associated with group home status is explained by the other covariates in the model – such as race and placement instability. In contrast, the effects of group home status remain significant in relation to permanency and adoption even when controlling for age, race, gender, and placement instability (Table C-5 and Table C-6). These differences are primarily due to the differences associated with the adoption rate. ***Only 3% of group home cases close in adoption, compared with 21% of the foster care cases.*** In short, group home placements significantly decrease the chances for achieving permanence; and this effect is largely due to differences with adoption rather than family reunification. ***There are no significant differences with regard to achieving family reunification.***

The remaining significant predictors are consistent with much of the child welfare literature. African-American and Hispanic youth are less likely to achieve adoption or family reunification. Older youth are also less likely to achieve adoption. Finally, placement instability significantly reduces the likelihood of achieving family reunification. The decrease likelihood of achieving permanency is almost always associated with a decrease likelihood of achieving adoption.

[140] The third column in each table, Exp(b), is the estimated odds ratio. This ratio estimates the change in the odds of membership in the target group (e.g., those that achieved reunification) for a one unit increase in the predictor variable.

Table C-4: Logistic Regression: Group Homes and Family Reunification (n=32,197)

Independent Variables	Model 1			Model 2			Model 3		
	b	Se	Exp(b)	b	Se	Exp(b)	b	Se	**Exp(b)**
Placement Status									
Group Home	-.164*	.08	.85	-.05	.09	.95	.18	.09	**1.19**
Child Demographics									
Age at placement				-.01*	.01	.98	-.01	.01	**.99**
African-American				-.24*	.07	.79	-.22*	.07	**.80**
Hispanic				-.16*	.06	.85	-.17*	.06	**.84**
Asian				.05	.14	1.05	.02	.15	**1.02**
Male				-.01	.05	.98	.01	.05	**1.01**
Maltreatment History									
Neglect				-.01	.05	.99	-.01	.05	**.98**
Placement Instability									
Two placements							-.26*	.06	**.77**
Three placements							-.44*	.08	**.65**
Four+ placements							-.72*	.07	**.49**
Model Chi-Square (df)	**4.33 (1) ***			**29.51 (7)***			**139.84 (10)***		

*p<.01

Table C-5: Logistic Regression: Group Homes and Permanency (n=32,197)

Independent Variables	Model 1			Model 2			Model 3		
	b	Se	Exp(b)	b	Se	Exp(b)	b	Se	**Exp(b)**
Placement Status									
Group home	-1.65*	.05	.19	-.69*	.05	.50	-.70*	.05	**.50**
Child Demographics									
Age at placement				-.15*	.01	.86	-.15*	.01	**.86**
African-American				.01	.04	1.01	.01	.04	**1.01**
Hispanic				-.18*	.04	.83	-.18*	.04	**.84**
Asian				-.21*	.09	.81	-.20*	.09	**.81**

Independent Variables	Model 1			Model 2			Model 3		
Male				-.01	.03	.98	-.01	.03	**.98**
Maltreatment History									
Neglect				.06*	.03	1.06	.07*	.03	**1.07**
Placement Instability									
Two placements							-.07*	.03	**.93**
Three placements							.05	.04	**1.01**
Four+ placements							-.01	.04	**.99**
Model Chi-Square (df)	**1529.09 (1) ***			**5804.66 (7)***			**5814.22 (10)***		

*p<.01

Table C-6: Logistic Regression: Group Homes and Adoption (n=32,197)

Independent Variables	Model 1			Model 2			Model 3		
	b	Se	Exp(b)	b	Se	Exp(b)	b	Se	**Exp(b)**
Placement Status									
Group home	-2.17*	.10	.11	-.64	.10	.53	-.91*	.11	**.40**
Child Demographics									
Age at placement				-.23*	.01	.79	-.25*	.01	**.77**
African-American				-.35*	.04	.70	-.37*	.05	**.69**
Hispanic				-.39*	.04	.68	-.38*	.04	**.68**
Asian				-.62*	.12	.54	-.61*	.11	**.55**
Male				.03	.03	1.02	.01	.03	**1.01**
Maltreatment History									
Neglect				-.04	.03	.96	-.03	.03	**.97**
Placement Instability									
Two placements							.23*	.04	**1.26**
Three placements							.64*	.04	**1.80**
Four+ placements							1.02*	.04	**2.77**
Model Chi-Square (df)	**908.01 (1) ***			**5787.15 (7)***			**6332.82 (10)***		

*p<.01

APPENDIX D – QUALITATIVE FACT-FINDING: SITE VISITS AND INTERVIEWS

SITE VISITS

DCFS GROUP HOMES

Aviva Children and Family Services, Hollywood
United Care Inc., South Central
Five Acres, Altadena
Maryvale, Rosemead
Fred Jefferson Memorial Home - Compton House
Fred Jefferson Memorial Home - Denker House
Mozell-Pennington's Boys Center, Compton
Vista Del Mar, Los Angeles
Hillside Home for Children, Pasadena
Manna Manor, Carson

PROBATION GROUP HOMES

Boys Republic, Chino Hills
Rancho San Antonio, Chatsworth
Children Are Our Future, Chatsworth
Erickson Center, Van Nuys

DCFS/PROBATION GROUP HOMES

Optimist Club, Los Angeles

LOS ANGELES COUNTY DEPARTMENT INTERVIEWS

DCFS Interviews (8)

Probation Interviews (2)

Judges (2)

Auditor-Controller (3)

Ombudsman

Association of County Human Service Agencies

County Counsel

Non-profit:

CHAMPS
Children's Law Center
Alliance for Children's Rights
Education Coordinating Council

APPENDIX E – REFERENCES

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A Big Step Forward to Clean Air and Fuel Economy

Hybrid Committee

George Buckley, Chair

Joe Contreras
Bob George
Lewis Hastings
Walter Lappo
John Visser
Ung Yol Yu

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

HYBRID VEHICLE REPORT

EXECUTIVE SUMMARY

The transition from gasoline powered county vehicles to cleaner and more efficient vehicles was directed by The Clean Fuels Policy, enacted by the Board of Supervisors in 1995. This policy was amended in 2005 to make hybrid vehicles (gasoline in combination with electric power) the standard where possible. The status of this transition was initially examined by the 2004-2005 Los Angeles County Civil Grand Jury, and the 2006-2007 Jury voted to investigate the current status and adherence.

In meetings with both the County and City procurement departments, the Civil Grand Jury found good progress in their implementation plans.

The variety of alternative fuel types has been closely examined and it has been determined that the hybrid vehicles provide the best combination of ecological and economic benefits.

The conversion process is limited by hybrid vehicle availability, the planned replacement program, and the suitability of such vehicles. Availability is hampered by the growing public response to hybrids. The pace of transition is geared toward normal replacement schedules. Certain emergency and heavy-duty vehicles are not suited to such replacement at this point of hybrid development. Nearly 300 of the County's 3600 vehicles and 800 of the City's 6,000 eligible vehicles are now hybrid or alternative fuel types.

The Grand Jury's recommendation is that both the County and City continue to actively and aggressively pursue this transition for both its clean air benefits for the community and its economic benefits to the taxpayers.

HISTORY

The 2004 – 2005 Los Angeles County Civil Grand Jury conducted an investigation to determine how the county evaluated and acquired passenger cars. Their intent was to encourage the use of hybrid automobile technology within the County fleet, based on the goals of reducing costs and the reduction of greenhouse gases.

The Jury's recommendation was that the Los Angeles County Board of Supervisors direct all County departments and agencies to replace their gasoline passenger vehicles scheduled for replacement, other than emergency or other specialty vehicles, with hybrid vehicles beginning in fiscal year 2006-2007.

PURPOSE

The 2006 – 2007 Civil Grand Jury agreed with the findings of the 2004-2005 Civil Grand Jury and formed the Hybrid Committee to investigate the response to that Grand Jury's recommendation and the Board of Supervisors' directive.

INVESTIGATION

The Civil Grand Jury visited both the County and the Los Angeles City Fleet Departments to understand their plans, programs, and progress, since the 2004-2005 Jury's report.

FINDINGS

First, the Civil Grand Jury found that the Internal Services Department, ISD, concurred with the 2004-2005 Grand Jury's recommendation to introduce more hybrid vehicles. ISD would be the key player in this effort as they were responsible for the acquisition of vehicles for all County departments (including Sheriff, Fire, and Public Works) as well as maintenance and repairs for 33 County departments and agencies. Since there was no policy in place, ISD proposed that the Clean Fuels Policy be revised. A motion mandating the purchase of hybrid vehicles was presented to the Board of Supervisors for its approval. The Board of Supervisors approved this motion November 15, 2005.

The Civil Grand Jury also found that the 2004 – 2005 Jury's recommendation was supported by an earlier action of the Board of Supervisors. On January 10, 1995, the Board enacted Policy # 3.020, the Clean Fuel Program (see attachment). This policy established a clean air policy to improve air quality in the South Coast Basin through the expanded use of clean fuels in conjunction with other County sponsored environmental programs to the extent it would be financially feasible. In addition, The Board of Supervisors concluded that overall operating costs could be lowered by acquiring more fuel-efficient vehicles for the county fleet. The U. S. Department of Energy's National Renewable Energy Laboratory estimated the cost savings to be $8,000 over five years for a hybrid vehicle when compared to a traditional gas powered vehicle.

The Board's interest in cleaning the air in Southern California, as well as lowering fleet expenses led them to move in their November 15, 2005 meeting, to the following actions: (1) to modify the current Clean Fuel Policy to ensure that hybrid vehicles become the standard for new non-emergency passenger sedans acquired to conduct routine County business;(2) to direct County departments, whenever feasible, to acquire hybrid passenger sedans, as they replace the gasoline powered passenger sedans, beginning no later than July 1, 2006; (3) and instruct ISD to submit a revised Clean Fuels Program policy, including a report on costs, to the Audit Committee for review and approval.

ISD management and staff have been very active in evaluating and investigating alternative vehicles for use in the County. The ISD fleet is managed on a seven year, 100,000 mile replacement program. They estimate that one hundred (100) of the 900 passenger vehicles will be replaced yearly. As of fiscal year 2006-2007, there are seventy-four (74) Hybrid vehicles on order. Ten (10) of these vehicles are designated for the Board of Supervisors. In addition to the passenger vehicles there are six (6) SUVs on order. ISD management and staff have been very active in evaluating and investigating ISD management and staffs have been very active in evaluating and investigating expensive and less fuel-

efficient. This will not preclude continued evaluation of future possibilities. ISD will also initiate a trial of a plug-in hybrid vehicle, PHEV. This vehicle is modified to be capable of being recharged on a standard 110/120 volt outlet.

ISD Vehicle /Fuel Type Inventory 2007

Inventory		Vehicle Type		Fuel Type	
Owned	3775	Passenger	1085	Gasoline	3446
Leased	8	SUVs	126	Hybrid	170
		Vans	1037	Electric	0
		Pickups	1333	CNG	31
		Heavy Trucks	202	CNG/Gas	10
				Diesel	106
				Ethanol/Gas	14
				Methanol/Gas	5
				Propane	1
Total	3783	Total	3783	Total	3783

This inventory has the following changes:

Passenger	+ 122
SUV	+ 3
Vans	+ 68
Pickups	- 1
Heavy Trucks	- 28
Gasoline	+ 165
Hybrid	+ 103
CNG	- 30
Diesel	- 87
Ethanol/Gasoline	N/C
Methanol/Gas	+ 4
Propane	- 1

ISD has initiated, in their effort to provide the best technology available, the use of ethanol/gasoline offerings. Since the last inventory they have added fourteen (14) of these vehicles for evaluation. ISD has also investigated the availability of hybrid pickups, vans, and SUVs. That research has demonstrated that the Silverado hybrid model, for example, only gets two miles per gallon more than a non-hybrid. Therefore, this category of vehicle is not cost efficient. The hybrid SUVs that are available, the Toyota Highlander and the Ford Escape, meet only a small amount of department needs.

As of this date full size hybrid SUVs are not available. However, many models from several manufacturers are in development and will be announced over the next few years.

As a comparison, and to include vehicle information about the Los Angeles City fleets, the following is submitted. The 2006-2007 Hybrid Committee thought it would be valuable to compare and contrast the efforts and results of these two entities. The City of Los Angeles utilizes both hybrid technology as well as other alternative fuel vehicle. Their efforts have been steered by two directives: first the City of Los Angeles in February 1996 joined the United States Department of Energy, (DOE) Clean Cities Program (see attachment) by forming the City of Los Angeles Clean Cities Coalition, and secondly by a May 2000 City Council adoption of the Clean Fuels Policy, CF 00-0157, (see attachment). Both these directives promoted the use of alternative fuel vehicles (AFV).

The City of Los Angeles began using hybrid automobiles in 2001. The first vehicle used was the Honda Insight. The initial response was essentially negative. This negative response was from both users, regarding vehicle size, and from others regarding the true cost of ownership. The next model used was the Honda Accord, which received a much more favorable response. The City has continued to expand its fleet and currently uses over 1,000 hybrids and other alternative fuel vehicles.

City of Los Angeles Fleet/Department of General Services 2006

Inventory		Vehicle Type		Fuel Type
Owned	11403	Sedan	4	Hydrogen fuel cell
Leased	5	Sedan	5	CNG
		Sedan	762	Hybrid
		Sedan	776	Gasoline
		Pickup Trucks	20	CNG
		Pickup Trucks	3	Hybrid
		Pickup Trucks	978	Gasoline
		Light trucks	14	Diesel
		Light trucks	683	Gasoline
		Street Sweepers	19	CNG
		Street Sweepers	141	Diesel
		Heavy trucks	4	CNG
		Heavy trucks	1121	Diesel
	`	Heavy trucks	740	Gasoline
		Refuse Trucks	4	CNG
		Refuse Trucks	8	LNG
		Refuse Trucks	252	LNG/Diesel
		Refuse Trucks	433	Diesel
		SUV	1	Electric
		SUV	168	Gasoline
	Subtotal		6137	
		Other*	5271	
	Total		11408	

* Other vehicles managed by the City within their fleet include Turf Tools, Shop Sweepers, Construction Equipment, Trucksters, Transport Trailers, Equipment, Mounted Trailers, Small Equipment, Aerial Equipment, and Aircraft.

The City of Los Angeles also has five other fleets that are independently managed by the Police, Fire, Water and Power, Harbor and Airport departments. Detailed information on those fleets is not included in this report.

The Department of General Service fleet replacement program is based on the type of vehicle. The criteria are as follows:

Sedans	7 years, 84,000 miles
Pickup Trucks	8 years, 96,000 miles
Street Sweepers	6 years
Refuse Trucks	7 years, 110,000 miles
SUVs	8 years, 96,000 miles

The hybrid sedans in use are the Toyota Prius, Honda Civic, Honda Insight, Ford Escape, Toyota Camry, and the Honda Accord. One obstacle to utilizing more hybrids is availability. Public acceptance and demand for these vehicles is putting the fleet users in a difficult position. Dealers are anxious to fill the public demand at higher prices and profits to their dealership. However, production rates are increasing and fleet orders are being filled.

The City's experience with maintenance has been very positive. The single most expensive part is the battery. The warranty on these batteries is 6 or 7 years based on the manufacturer. To date, no battery has failed. Overall, the maintenance costs are comparable for hybrids and their gasoline counterparts.

Los Angeles operates several fueling stations for their fleet along with additional locations under development. The City has been testing hybrids/alternative fuel offerings since 2001 when they tested the Honda Insight. The City is also testing four hydrogen fuel cell SUVs from Honda. Their evaluation to date concludes the plug-in hybrid is not feasible.

CONCLUSION

While the County is only in the first year of this effort, it has established a sound plan, and met its first year goal. In combination with the City, there has been significant progress in the utilization of the improved technology of alternative fuel vehicles.

RECOMMENDATIONS

The Internal Services Department of Los Angeles County and the Fleet Services Department of Los Angeles City have been active and proactive regarding the evaluation and use of hybrid and alternative fuel vehicles. Based on the Board of Supervisors' direction, the County has enacted a plan to acquire hybrid vehicles.

The Grand Jury recommends that the County and the City of Los Angeles continue efforts to investigate, test, and evaluate new offerings as well as to continue with the planned replacement of vehicles with hybrid and alternative fuel options. It is the committee's recommendation that the County accelerate its effort to add AFVs. With this action, the county will comply with the direction of the Board of Supervisors and contribute to cleaner air and lower fuel costs.

ABBREVIATIONS

AFV Alternative Fuel Vehicles
CNG Compressed Natural Gas
DOE Department of Energy
ISD Internal Services Division
LNG Liquid Natural Gas
PHEV Plug-in Hybrid
SUV Sports Utility Vehicle

ATTACHMENTS

Board of Supervisors Policy Manual
Policy # 3.020

Los Angeles City Council
Clean Fuels Policy
CF 00-0157

The Department of Energy
Clean Cities Program

Policy #:	Title:	Effective Date:
3.020	**Clean Fuel Program**	**01/10/95**

PURPOSE

Establishes a clean air policy to improve air quality in the South Coast Basin through the expanded use of clean fuels in conjunction with other County-sponsored environmental programs to the extent it is financially feasible.

The goal is to transition as many vehicles to clean fuels as possible within the limits of service delivery requirements and funding capabilities.

REFERENCE

September 20, 1994 Board Order, Synopsis 9

November 30, 1994 Chief Administrative Office and Internal Services Department memo, "Los Angeles County Clean Fuels Policy"

January 10, 1995 Board Order, Synopsis 8

POLICY

It is the policy of the County of Los Angeles to transition its motor vehicle fleet to viable clean fuels as approved by the California Air Resources Board. Transition to clean fuel will be based on the use of the vehicle, availability of fuel, and funding. The Clean Fuels Policy shall be executed in compliance with the following guidelines:

1. Each department head shall be responsible for implementation of the Clean Fuels Policy within his/her department.

2. Whenever possible**,** new vehicle purchases will be clean fuel vehicles.

3. Implementation of the Clean Fuels Policy shall depend on the financial resources available to the County. Departments shall pursue funding available from a variety of sources and may work with other public/private agencies to share resources, coordinate efforts, and apply jointly for available

funds.

4. Departments shall report to the Board by March 1st each year on the composition of their fleet and the number of vehicles powered by clean fuels.

RESPONSIBLE DEPARTMENT

Internal Services Department

Chief Administrative Office

DATE ISSUED/SUNSET DATE

Issue Date: January 10, 1995
Review Date: February 19, 2004
Sunset Review Date: January 10, 2004
Sunset Review Date: January 10, 2007

Clean Fuels Policy (CF 00-0157)

In May of 2000, the City Council adopted a Clean Fuels Policy (CF 00-0157). This policy helps to implement alternative fuel applications by supporting programs and regulations that balance environmental benefits against operational concerns such as safety, efficiency, and cost effectiveness. Specifically, the City Council decided to: use and purchase vehicles which utilize clean fuels and/or electric propulsion based upon technology that has been determined to be reliable, durable, and cost-effective; support development of vehicle technologies that promote energy efficiency and clean operation; consider retrofit technologies for existing vehicles; promote development of alternative fuel infrastructure; support implementation of federal and state vehicle emission standards; and address health and safety issues and cumulative impacts of existing and alternative fuel technologies on all neighborhoods, particularly low income communities of color. Council member Mark Ridley-Thomas authored the Clean Fuels Policy and received a Clean Air Award from the South Coast Air Quality Management District (Leadership in Government Category) in 2001 for this legislative initiative.

For further reading see:

Mark Ridley Thomas' motion

Environmental Quality and Waste Management Committee Report

Council Action to Adopt Policy

LOS ANGELES CLEAN CITIES COALITION BACKGROUND

In February 1996, the City of Los Angeles joined the United States Department of Energy (DOE) Clean Cities Program by forming the City of Los Angeles Clean Cities Coalition. In 2002, the City was approved for its 5 year renewal, indicating Los Angeles' continuing commitment to improving air quality. The Coalition supports the voluntary deployment of alternative fuel vehicles (AFVs) and construction of infrastructure to support AFVs and includes 18 Principal Stakeholders and 10 General Stakeholders, who may participate on a project per project basis. The Principal Stakeholders consist of key City departments. The General Stakeholders consist of government agencies, utilities, and non-profit organizations committed to improving air quality in the Los Angeles area. The goals of the City of Los Angeles Clean Cities Coalition are to:

- Work to increase the City's overall AFV fleet inventory by 15%, as a target goal, each fiscal year
- Identify opportunities to maximize the deployment of AFVs in City fleets
- Encourage the adoption of policies that promote the use of AFVs
- Enhance the support for AFV use by facilitating the expansion and increased utilization of AFV refueling/recharging infrastructure in the City
- Support local job creation and economic development opportunities related to the AFV industry through efforts to deploy AFVs in City fleets and enhance AFV use in the City

Between 1996 and 2001, the number of clean fuel vehicles in the City's fleet increased from 279 to 807, an average increase of over 23% per year. During this time, the City also supported the installation of alternative fuel infrastructure, including a fast-fill compressed natural gas (CNG) refueling station in downtown Los Angeles, a liquefied natural gas (LNG) refueling station at Los Angeles International Airport (LAX), and approximately 400 electric vehicle (EV) charging stations throughout the Los Angeles area. In May 2000, the City Council adopted a Clean Fuels Policy (CF 00-0157) that encourages the use of alternative fuel applications in the City. In addition, the City is required by the Fleet Rules, adopted by the South Coast Air Quality Management District (SCAQMD) in 2000 and after to acquire alternative fuel vehicles in most City operations when adding or replacing vehicles in the fleet. Thus, it appears that AFVs will have a continued and increasing role in the City's fleet. In 2004, the number of AFVs increased to 2071, an average of 37 percent per year from 2001 through 2004. As of June 2005, there were over 2400 alternative fuel vehicles in the City's fleet.

Participation in the Clean Cities Program provides the City with grant opportunities only available to Clean Cities Coalitions and provides national recognition for the innovative alternative fuel projects spearheaded by the City. Past DOE grants are listed at this link. Regarding recognition, the DOE awarded the City of Los Angeles as one of the Top Ten Clean Cities in 2000. In addition, the Los Angeles Coalition has been presented with several Clean Cities awards, including the Rainmaker Award for securing the most funding from grants and other sources (1999) and the Gold Star Award for adding the most AFV fueling stations (1999, 2000). In 2001, the Clean Cities Legal Eagle Award was received for Advancing AFV Legislation. In 2004, an Excellence in Advancing Propane award was received.

In 1994, the DOE created the Clean Cities Program to serve several objectives, both locally and nationally, including: 1) progress toward attainment of federal and state air quality standards; 2) enhanced penetration of clean fuel vehicles; 3) energy security and resource conservation; and 4) economic stimulation in areas that have been heavily impacted by the economic recession and cutbacks. There are currently 88 Clean Cities Coalitions throughout the United States. DOE requires Clean Cities Coalitions to report regularly on activities and achievements and appoint a Clean Cities Coordinator.

For information about the Clean Cities Program, please contact the Air Quality Division at heloise.froelich@lacity.org.

If you are interested in contacting the National Clean Cities Program directly please call their Clean Cities Hotline at (800) 224-8437or (703) 934-3068 or via e-mail at ccities@nrel.gov

LAHSA

The Struggle to Serve

LAHSA Committee

Sandra Lee Mohr, Chair

Joe Contreras
Walter Lappo
Connie Leyba
Marlene Markheim
Otha Scottt

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

LAHSA – THE STRUGGLE TO SERVE

After a troubled period, the Los Angeles Homeless Services Authority has now stabilized its operation---but it needs much more City and County involvement to do its crucial job

EXECUTIVE SUMMARY

Homelessness has been a pervasive and continuing problem in the City and County of Los Angeles for many years. As the result of a lawsuit, the City and the County agreed to establish a joint powers authority, the Los Angeles Homeless Services Authority (LAHSA). This Authority was authorized to take over the distribution of grant funds from a variety of Federal, City and County sources to the private contractors who provided direct services to the homeless.

Serious concern about LAHSA's ability to function effectively developed in the years after it was given autonomy in 2001. These issues came to a head by 2005, prompting the City Controller and the County Auditor to intervene. LAHSA was then severely criticized for operational problems and inappropriate (though not fraudulent) handling of grant funds passed through to contractors servicing the homeless.

Since that time, the Los Angeles Homeless Services Authority (LAHSA), with considerable outside support (extensive audits, procedural changes and significant interim financial oversight and management*),* has been able to perform more effectively as a pass-through agency for funds granted for care of the homeless.

LAHSA, therefore, continues to perform a critical and necessary role in receiving funds from HUD, the City and the County of Los Angeles and other sources, and to distribute them to some 90 non-profit contractors who provide direct services to the homeless.

However, in order to continue to properly carry out its charter (as originally established in 1993 by a Joint Agreement between the City and the County) LAHSA requires substantial staff upgrading and expansion and, especially, further support and increased oversight from both the City and the County.

Starting with five simple contracts to service in 1993, and a staff of thirteen, the Authority now administers 200 complex contracts with a staff of 70. LAHSA's financial control requirements have also greatly increased because of greater and more complicated requirements from the various funding sources.

At the same time, until recently, LAHSA has continued to function without either an Executive Director or a qualified Chief Financial Officer on staff.

In order to insure a sound foundation and the proper capability of carrying out its significant responsibilities, LAHSA requires:

- closer and stronger County and City oversight
- creation of a broader, stronger governance body
- an increase in staff
- an upgrade in key staff positions
- a review of some of the more time-consuming accounting requirements made by some funding sources
- a fully qualified Chief Financial Officer
- the addition of a Director to administer both the Financial and the Contract areas
- creation of a special section to continually monitor contract servicers

- a Line of Credit to cover gaps between servicers' requests and remittances from funding sources
- annual reviews of its operations by the City and County Controllers
- implementation of the Homeless Management Information System

HISTORY

Prior to 1993, the processing of funds from HUD and other sources for the care of the homeless was handled within Los Angeles County and City organizations.

In acquiring these responsibilities, LAHSA thus became the "lead agency" for Los Angeles for distribution of federal funds, a HUD requirement for every large city.

Until 2001 the County and the City continued to manage the accounting concerns of LAHSA's operations. In that year this responsibility was turned over to the Authority itself, with County and City oversight greatly reduced.

Starting with a staff of thirteen, the size and workload of LAHSA has grown as the processing of requests from servicers and the draws from funding sources has expanded dramatically in number and complexity. The staff has similarly grown to between 60 and 70.

Funding in these years increased from the initial $5,000,000 to over ten times that amount in some years. Contracts being serviced increased from the original 5 to forty times that number. More rigid and complex restrictions on funding requests complicated the receipt
of funds due service contractors, and the wide variety of service contractors involved led to a variety of problems in receiving and processing requests in a timely manner.

This combination of conditions caused LAHSA to be frequently unable to receive funds within the time that contractors needed them, and led to LAHSA sometimes commingling funds from inappropriate grants to meet those needs. This situation resulted in LAHSA owing major amounts to servicers without having the funds available to pay them.

The limitation on funds designated for LAHSA's administrative expense and the occasional delays in transferring them resulted in LAHSA's inability to meet payroll on occasion.

As the challenging work load increased during these years, LAHSA's staff was not sufficiently qualified in some instances to properly handle the more complicated requirements, particularly in the financial area. Necessary training, upgraded procedures, and improved operating policies were not able to be provided because of the complex work load.

The lack of strong, positive management was a major factor contributing to LAHSA's inability to cope with these increased demands.

By mid-2005 the operations of LAHSA were in serious disarray, owing to the increased and more complex workload, the loss of the Executive Director and the Chief Financial Officer, and the limited

qualifications of some of the staff in key areas. Systems, policies and procedures had not been evolved to meet the greatly expanded work demands.

A review by the Los Angeles Housing Department (LAHD) reported that servicers were not paid and monies needed from funding sources were not being requested in a timely manner. Over $5,000,000 owed at one point in early 2005 with only $700,000 on hand because of delays in requesting grant funds. Commingling of funds (funds being drawn from sources intended for and restricted to other purposes) was done at times to pay some of the servicers. The fiscal closing of the books had not been done for 2004 and 2005.

An audit by Laura Chick's office identified all of these problems, and indicated serious concerns about the capabilities of the existing staff. A report quoting these problems appeared in the Los Angeles Times. *

To address these urgent problems an intensive and extensive examination was made by the County Auditor/Controller's office along with the Blue Consulting firm to fully audit LAHSA, to install a senior consultant as acting CFO, and to cause extensive rewriting of operating policies and procedures. This work lasted from October, 2005, through March of 2006.

As a result of this combined effort, and with the close involvement of the interim Chief Financial Officer provided by Blue Consulting, accounts were reconciled, new policies and procedures were implemented, and intensive training was done to better prepare key staff members to maintain the suggested improvements

The Simpson and Simpson audit firm has since completed the work of closing the fiscal books for 2004 and 2005.

* Los Angeles Times, July 23, 2005, Pg. B.3

Significantly, **no instance of any fraud was found in any of the audits.** One instance involving the misappropriation of three checks was immediately discovered and stopped by LAHSA itself. The problems that had occurred were produced by a combination of ineffective management, especially in the financial controls area, the rapid increase in volume and complexity of work, and the inadequate training and staffing that existed. However, serious challenges for LAHSA remain.

FUNDING SOURCES, DESIGNATED PURPOSES: LAHSA BUDGET 2006-07 *

Sources of Funding Designated for:	L.A. City	L.A. County	State	HUD	Total
Housing	$ 1,169,000	$ 1,975,386		$ 29,987,736	$ 33,132,122
Shelter	8,639,844	9,137,531	146,136		17,923,511
Other	6,187,959	351,007			6,538,966
LAHSA directly administered prog.	245,120	3,064,309			3,309,429
LAHSA administration	1,540,126	2,035,160		73,293	3,648,579
Funding Totals	$ 17,782,049	$ 16,563,393	$ 146,136	$ 30,061,029	$ 64,552,607

* Figures summarized by primary source, purpose.

The Los Angeles Times articles criticizing the operations of LAHSA, exposed by the Laura Chick audit, sparked the interest of the 2006-2007 Los Angeles County Civil Grand Jury and resulted in the formation of the LAHSA Committee.

The underlying or primary concern was to investigate whether the homeless community meant to be serviced by the funds distributed by LAHSA was indeed receiving proper benefits.

The investigation determined to understand and evaluate the following concerns:

- LAHSA's financial control problems
- LAHSA's operational problems
- LAHSA's relationship to contract servicers
- LAHSA's evaluation of the actual service made to the homeless
- the need to identify and recommend needed changes, upgrades, etc.
- the need to identify and recommend needed changes in the relationship of

LAHSA to its sources of funding, to its contract servicers, and to the City and the County

INVESTIGATION

METHODOLOGY

To research these concerns and to determine appropriate recommendations, the LAHSA Committee of the Civil Grand Jury carried out these actions:

- review of the Laura Chick audit report
- review of all historic LAHSA documents – original agreement, subsequent modifications, etc.
- review of various newspaper reports on the Internet
- attendance at LAHSA Commission monthly meetings
- interview with the new LAHSA Executive Director
- interviews with key LAHSA administrative staff members
- interviews with senior members of the County Auditor/Controller's staff
- discussion with appropriate key personnel
- interview with the Blue Consultants interim Chief Financial Officer
- interview with LAHD Director and staff
- review of LAHD Director's 2/06/06 report and recommendations to Mayor Villaraigosa
- field visits to a number of contract servicers
- review of the Blue Consultants audit and report of implemented policy and procedure changes
- review of Simpson and Simpson fiscal audit closing LAHSA books for 2004 and 2005
- tour of Skid Row with LAHSA's Emergency Response Team

FINDINGS

Among the results from the Committee's investigation was the recognition that, though the fiscal problems of LAHSA were quite severe by 2005, there was and has not been discovered any instance of fraud. The only occasion of financial impropriety was the attempted misuse of three LAHSA checks by a staff person. The missing checks were promptly found and the person dismissed.

A more consequential knowledge gained was the substantial expansion, upgrading, and training that is necessary for the LAHSA staff to carry out its duties. In addition to increasing the staff, a higher level of compensation and qualification is required for the key administrative positions, particularly in the Fiscal Department.

Expanded training, revamped policies and procedures, more efficient organization and review of certain demanding restrictions from fund sources are further needs.

LAHSA is rigidly restricted by the requirements of funding sources to not being able to pass through funds to service contractors in a timely manner. A Line of Credit is a critical need to relieve this serious difficulty.

Strong management over the Fiscal and Contract Departments is critical and a new position of Director over both areas is needed to improve coordination and efficient functioning between the two.

While a critical responsibility for LAHSA is the monitoring of its 90 service contractors, the operational problems of recent time, the expansion and further complication of its duties, and the absence of effective management has caused the Authority to largely be unable to provide this necessary function. Since turning over fiscal management to LAHSA in 2001 the County and the City have largely let the Authority function without appropriate attention, allowing the difficulties that developed by June of 2005 to reach such an extreme.

The County and the City should monitor the fiscal and operational functioning of LAHSA to more frequently insure its sound operation. They should provide special assistance when actions can be taken to smooth their interface with LAHSA and to give earlier warning of any sign of lapsing.

The thoroughness of the several audits recently performed has identified these needs clearly. The interim Chief Financial Officer has contributed significantly to the implementation of needed revised procedures and policies, instituted substantial staff training, and improved the efficiency of many operations.

The recent hiring of an Executive Director offers good hope that LAHSA will have the strong voice and leadership it has lacked for far too long. However, a permanent Chief Financial Officer has yet to be acquired. This position will be critical to the long term success of LAHSA.

The 2006-2007 Los Angeles County Civil Grand Jury LAHSA Committee believes the following requirements are necessary for LAHSA to successfully carry on its vital duties for not only the immediate future, but for the long term.

RECOMMENDATIONS

1. COUNTY AND CITY OVERSIGHT

While LAHSA continues to manage its own fiscal and contract operations, and while it is audited by an outside firm annually, the County and the City should be more closely involved on at least an annual basis to confirm that LAHSA is functioning as intended. Whether this requires an actual audit, or a selective reporting and visiting effort is yet to be determined, but ongoing validation is necessary, given the amount of funds involved and how rapidly control can be lost if close attention is not paid.

The County and the City should replace the existing LAHSA Commission. The recommendations for a new decision making governance, as proposed by the LAHD Director in the 2/06/06 report to Mayor Villaraigosa, should be carefully considered. This would enable LAHSA to fulfill its proper role in the care and servicing of the homeless in the City and the County.

This governance would be managed by a new LAHSA Commission that would include the heads of City and County departments that control the available resources for housing and services. It would also include leaders from other cities throughout the County. This would be comparable to the Housing Coordinating Committee.

In this regard, a study should be made of successful homeless operations in such cities as San Francisco and New York.

2. STAFF INCREASE

A careful evaluation should be done by LAHSA to identify the numbers and types of additional employees needed to be effectively staffed. This should include not

3. STAFF UPGRADE

LASHA must upgrade its staff to meet its current and increasing operational challenges. Especially in the Fiscal area, not only additional staff should be hired, but existing staff should have thorough, ongoing training to acquire the full understanding of their duties and to insure their reliable performance.

4. ADMINISTRATIVE ADDITION

A Director of Operations position should be created and filled by LAHSA. This position to have direction over both the Fiscal and the Contract Departments. This will enhance their efficient functioning in processing the work that passes back and forth between the two areas, and improve the timeliness of fund requests and payment distributions.

5. CHIEF FINANCIAL OFFICER

LAHSA must have a fully qualified Chief Financial Officer. While this position is currently filled on an interim basis by an audit firm consultant, and while the search for a permanent replacement has been carried on for some time, the need continues. This person will be the key acquisition in the effective meeting of LAHSA's fiscal responsibilities. This position is reported close to being filled.

6. LINE OF CREDIT

LAHSA must secure a line of credit to fill the gap between servicers' requests and the release of funds from funding sources.

While at this point efforts are indeed being made to secure such a financial support for LAHSA, the need is permanent and substantial. Whether through a coordinated support from the City and the County, or from outside financial sources, this need must be met.

7. REVIEW OF STRINGENT FUND REQUEST ACCOUNTING

Because of the extreme concern about the commingling of funds, stringent controls were imposed by LAHD on the request for funds. While entirely appropriate at the time, these controls, though recently eased, require substantial additional efforts by LAHSA's staff to prepare fund requests on a timely basis.

Similarly, the accrual adjustments required by the County Community Development Commission for their own accounting needs cause considerable extra effort on LAHSA's staff.

LAHSA should meet on a continuing basis with appropriate representatives from all funding sources to review the working relationships, the control requirements, and the possibility of moderating the stringent funding request requirements.

8. LAHSA CONTRACTOR MONITORING SECTION

LAHSA should organize a section dedicated to continually monitor and make risk assessments for the service contractors funded by LAHSA. This is a requirement for HUD's continued funding, but also provides validation that the funds being distributed are indeed properly reaching the Homeless, as intended.

This section should also complete the 100% source documentation reviews of Department of Housing and Urban Development Supporting Housing Program contractors. This has been acknowledged by LAHSA's proposed 2007 budget.

9. CENTRALIZED PROCESS FOR EXTERNAL AGENCY MONITORING REPORTS

A centralized process should be developed by LAHSA to manage and follow up on external agency reports to LAHSA. These external monitoring findings and recommendations should be integrated into the LAHSA management process.

10. IMPLEMENT THE HOMELESS MANAGEMENT INFORMATION SYSTEM

This system has not been able to be properly implemented by LAHSA because of its complexity and because of LAHSA's more urgent work overload. However, this system, when implemented, will not only meet HUD requirements but can supplysignificant reports on shelter usage, client intake, homeless demographics and success rates of people moving out of homelessness.

LAHSA should complete this installation promptly.

11. Until the time it can effectively audit the effectiveness of major contractors with its own designated staff, LAHSA should seek budget approval to hire an audit firm to perform this task

CONCLUSION

LAHSA, despite its past difficulties and ongoing concerns, remains the necessary vehicle for the proper and effective handling of the millions of dollars involved in contracting services for the homeless of Los Angeles City and County.

Expanded training, revamped policies and procedures, particularly more efficient organization and review of certain demanding restrictions from fund sources are further needs.

It requires the support itemized in the Recommendations listed to do its job more properly, dependably, and on a long term basis.

Sanitation Districts of Los Angeles County

From Problems to Progress

Sanitation Committee

Richard Lorne Davis, Chair

Emilie Anselmo
George Buckley
Stuart L. Chason
Lewis Hastings
Connie Leyba
Charles Repp Jr.
Lloyd Thornhill
John Visser

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

SANITATION DISTRICTS OF LOS ANGELES COUNTY
FROM PROBLEMS TO PROGRESS

After a period of disaster involving extensive sewage overflows occurring in 2006, the Sanitation Districts of Los Angeles County made significant progress in turning a detrimental situation into win-win results. These all benefited County's citizens and ensured future environmental control over events for which The Districts had initially faced censure and substantial fines proposed by the Los Angeles Regional Water Quality Control Board.

EXECUTIVE SUMMARY

In the beginning, the situation appeared chaotic. The press and internet media had widely reported that the County Of Los Angeles Sanitation Districts were responsible for having caused and/or permitted certain conditions to develop on or prior to January 15, 2006 which resulted in massive spills of raw sewage in certain beach city areas. Furthermore, the Sanitation Districts incurred potentially significant financial liability exposure for having failed to timely alleviate the consequential contamination to the public beach areas affected.. All of these conditions ultimately generated a proposed fine assessment by the Los Angeles Regional Water Quality Control Board in the sum of approximately 4.7 million dollars.

The Civil Grand Jury initially determined that these concerns warranted investigation of the following issues, felt to be clearly in the public interest and appropriate subjects for extended inquiry leading to the development of this Report, namely:

1. The whys and wherefores of this seemingly disastrous occurrence;
2. Its causal relation to the general operations of the Sanitation Districts;
3. The resultant contamination of the environment and publicly affected areas;
4. The remedial efforts undertaken to alleviate the occurrence results;
5. The measures planned to prevent recurrences; and
6. Evaluation of the realistic basis for the massive proposed fine assessment

HISTORY AND STRUCTURE OF THE LOS ANGELES COUNTY SANITATION DISTRICTS

The Los Angeles County Sanitation Districts (Districts) were designed to expedite the provision of environmentally sound and cost effective wastewater and solid waste management for over half the population of Los Angeles County, which involves a working arrangement for 24 independent special sanitation districts functioning cooperatively under a Joint Administration Agreement, with one central administrative staff under the direction of a Chief Engineer and General Manager, headquartered near Whittier, California.

The Sanitation Districts of Los Angeles County Headquarters

The 24 separate and independent sanitation districts who are parties to the Agreement were each created by State law in order to perform specified functions, and are all subject to the same laws appertaining to local agencies generally. Statutory authority for such special sanitation districts stems from the County Sanitation District Act under provisions of the California State Health and Safety Code. The County Sanitation Act also provides for a single centralized administrative organization with responsibility for furnishing joint administrative functions on behalf of all signatories to the Joint Administration Agreement. By the terms of said Joint Administration Agreement, governance of the Districts is vested

in a Board of Directors, consisting of the presiding officers of the governing boards of each city sanitation district signatory or supervisors of any unincorporated County territories.

The Districts' overall wastewater and solid waste management budgets for 2005-2006 were $590 million and $264 million, respectively, and provide customer service at some of the lowest rates in the entire County. The Districts' 1,300 miles of trunk sewers and 11 wastewater treatment plants convey and treat approximately 510 million gallons per day (mgd), 190 mgd of which are available for reuse in the dry California climate for irrigation and other non-potable uses. There are 3 active sanitary landfills which handle more than 19,000 tons per day (tpd), of which 1,600 tpd are disposed of and 3,500 tpd are recycled. The Districts also operate 3 landfill gas-to-energy facilities, 2 recycle centers, and 3 transfer/materials recovery facilities, and participate in the operation of 2 refuse-to-energy facilities. The Districts regularly derive a sizeable amount of operating funding from these sources, saving the County taxpayers many tax dollars in the process.

HISTORY AND CAUSES OF THE WASTEWATER SPILL ON JANUARY 15, 2006.

1. OPERATION AND MAINTENANCE PROGRAMS FOR DISTRICTS PUMPING PLANTS:

   This subject is reviewed because of the primary investigation into pumping plant failures. The Districts' pumping plants are designed to handle wet weather peak flows with at least one pump remaining in standby status. Other Districts' design standards for pumping plants include real time alarms, continuous monitoring of operating conditions through a telemetry system, and both emergency power and pumping equipment.

   Pumping plant Operators are responsible for inspections and operation of Districts' pumping plants. Mechanics and Electrical/Instrumentation (E/I) technicians perform preventive maintenance and repairs. Operating pumping plants are visited at frequencies varying from daily to once weekly. On each visit, the Operator observes the machinery to ensure proper operation through various predetermined inspection procedures. The Districts maintain a continuously staffed Central Alarm Center at the Long Beach Main Pumping Plant (LBMPP). Operators monitor the operation of 48 of the 52 pumping plants from this facility 24/7 through the use of the Pumping Plant Telemetry System.

   During non-working hours, the LBMPP operates as an emergency contact center for The Districts. An on-duty Operator takes calls and responds to emergencies. A second on-duty Operator is immediately dispatched when a complaint or emergency call is received. The on-duty Operator can contact any of the supervisors/managers in the Sewerage System Section 24 hours a day.

   All of The Districts' pumping plants are maintained in accordance with a Preventive Maintenance (PM) Program and Work Order System. The latter is used to identify and track repairs or other maintenance activities that require labor beyond what is performed under a PM task. Trained Operators, Stationary Mechanics and Electrical/ Instru- mentation Technicians perform the maintenance tasks.

2. SUMMARY OF THE CONTROL SYSTEM FAILURES ON THE DAY OF THE OVERFLOW:

The South Bay Cities Main Pumping Plant (SBCMPP) is one of 48 pumping plants remotely monitored from The Districts' 24-hour alarm center at the LBMPP. The SBCMPP is inspected 6 days per week. PM tasks are performed quarterly, semi-annually and annually. The quarterly PM tasks were last completed in October 2005, and the semi-annual PM tasks were completed in July/August 2005.

The operational status of each of the 48 pumping plants is continuously monitored at the LBMPP, utilizing a telemetry system which, at the time of the January 15, 2006 overflow, used analog telephone lines operated by Verizon and AT&T, (based on the areas served), to transmit status signals from various pumping plant groupings to the Alarm Center.

On January 15, 2006, after 5:00 a.m., the Verizon "Host Circuit 69" experienced a failure. Between 5:48 a.m. and 6:13 a.m., signals from 17 pumping plants west of the 110 Freeway, including the SBCMPP, were successively lost. The Districts had been experiencing repetitive communication failures with this group of pumping plants and had been working with both Verizon and AT&T to resolve the matter. To this date, Verizon has still not indicated to The Districts the reason for the Circuit 69 failure on January 15, 2006, or the steps taken to restore service.

Districts' Operators were dispatched to investigate the condition of each pumping plant experiencing communication failure. A loss of communication does not necessarily indicate a failure of operating equipment at a pumping plant, only that its operating status is unknown. In all previous communication failure incidents throughout The Districts, all pumping plant electrical and mechanical equipment operated without interruption. In fact, the SBCMPP had operated for over 20 years, through record rainfalls, power outages and communication failures without spilling a drop of wastewater. After confirming the proper functioning of 3 other pumping plants, the Operator arrived at the SBCMPP at approximately 10:15 a.m. and found that all 3 pumps were not operating, and that the pumping plant was flooded with wastewater.

Investigation following the overflow indicated the cause as being the failure of the primary pump control system at approximately 9:00 a.m. on January 15, 2006, with a coincident failure of the backup pump control system. Both systems are on a PM schedule, and both had been inspected and tested the first week of January 2006. At the time of such inspection, an uninterruptible power supply (UPS) was installed on the primary pump control system and both primary and backup systems were verified as operating properly.

Prior to January 15, 2006, The Districts had never before experienced spontaneous failure of both primary and backup systems at any pumping plant. The root cause of failure of the primary control system at the SBCMPP was determined by the Programmable Logic Controller (PLC) manufacturer to be an internal failure of the memory module within the PLC. The root cause of failure of the backup control system has not been conclusively determined. The ultrasonic level transmitter was subsequently tested, however, and observed to malfunction and display a constant value which did not correspond to the actual rising wastewater levels in the

pump station. Shortly following the overflow, both primary and backup control systems for the SPCMPP were completely replaced. It is significant to note that the January 15, 2006 failure at the SBCMPP did not involve any power failure.

REMEDIAL STEPS INITIALLY AND SUBSEQUENTLY UNDERTAKEN

Regarding The Districts' initial response to the overflow, upon arrival of the Operator at the SBCMPP on January 15, 2006, overflows were observed occurring at 5 locations from a total of 6 manholes in the Cities of Manhattan Beach and Hermosa Beach. Discharge to the ocean occurred at 2 of the overflow locations. Districts' crews responded, and vacuum trucks were used to remove approximately 500,000 gallons of wastewater from the sewer upstream of the disabled pumping plant during the ongoing overflow, reducing the total volume of wastewater spilled by that amount. Personnel from the County Department of Beaches and Harbors and the City of Hermosa Beach constructed three sand berms to contain the spilling wastewater, thus preventing continued overflow from reaching the ocean. Districts' Operators dewatered the pumping plant and deployed portable pumps in attempts to bypass the pumping plant. Before they could be implemented, however, simultaneous efforts by Districts' crews successfully restored operation of the stationary pumps in the SBCMPP.

One of the 3 pumps in the SBCMPP was returned to operation as of 12:55 a.m. on January 16, 2006, ending the overflow, following which vacuum trucks and a portable pump were used to remove wastewater from the containment berm areas on the beach. The total volume of wastewater spilled was 1,519,490 gallons. The total volume discharged to the ocean was 64,717 gallons. The total volume recovered from containment areas was 678,000 gallons. The total volume percolating into the sand that could not be recovered from the containment areas was 776,773 gallons. After all standing wastewater was removed, all of sand areas impacted by overflows were raked to remove visible debris of wastewater origin and contaminated sand. Remaining moist areas were then treated with dry chlorine, allowed to air dry for approximately 2 days, and on January 19, 2006 covered over with clean sand. The initial cleanup, performed using standard industry procedures, was approved by County Department of Health Services (DHS) personnel. Initial sand clean-up activities were completed by January 19, 2006, and the areas were reopened to the public by DHS.

To verify the efficacy of remediation efforts, Districts' Staff researched and developed sand sampling and analytical techniques to measure the bacteria in sand. At that time, there were no published tests or analytical methods for conducting such sand testing. On January 26, 2006, Districts' Laboratory Staff conducted sampling at the 21st Street Manhattan Beach site and several backgrounds sites unaffected by the overflows. This involved collecting subsurface sand samples and analyzing them for wastewater indicator bacteria, specifically fecal coliform and enterococcus. Results became available on January 31, 2006, and showed that there were atypical elevated levels of bacteria in the sand's subsurface at the 21st Street site. These test results were immediately shared with DHS, County Beaches and Harbors, and the City of Manhattan Beach. Although there are no local, state or federal health standards for bacteria in sand, it was collectively agreed that the affected sand areas should be restricted from public access until further remediation efforts were implemented. On January 31, 2006, the sand areas at 21st Street and under the Pier in Manhattan Beach were cordoned off from public access. The ocean waters remained open, as there was no related threat to public health.

IMPROVEMENTS UNDERTAKEN TO SBCMPP ALARM SYSTEMS

At the time of the January 15, 2006 overflow event, plant upgrades were already underway at the SBCMPP. New telemetry systems were also installed shortly after the overflow incident. The new primary telemetry system now in place utilizes digital frame relay telephone service from Verizon with each plant reporting directly to the Alarm Center rather than on serial circuits. The digital service is more reliable than the analog service it replaced, offering improved ability to rapidly diagnose problems. The configuration of the new system dramatically reduces the likelihood of simultaneous communication failures at more than one pumping plant. A second Alarm Center has been established at The Districts' Joint Water Pollution Control Plant (JWPCP) in Carson, using a different telephone carrier to back up the Alarm Center at the LBMPP. In addition, a backup telemetry system using cellular technology has been installed at each pumping plant to back up the primary telecommunication system.

The new pump control system, in place since March 10, 2006, utilizes a PLC with dual power supplies. Redundant differential-pressure level transmitters have been provided to sense the water level. The upgrade at the SBCMPP also included a UPS installed to provide backup power for the PLC and the telemetry equipment. In any failure of the primary control system, the redundantly configured backup control system will operate the pumping plant.

In addition to upgrades in the telemetry and control system, other telemetry upgrades have been performed at the SBCMPP, including installation of a new switchboard replacing the magnetic drives with new variable-frequency drives, replacing the electrical motors, and adding connections so that a portable generator could be used to power the pump station.

REMEDIAL BEACH RENEWAL AND RESTORATION

The goal of The Districts was to successfully sanitize the contaminated beach sand areas, and to restore them to their normal condition. 776,773 gallons of wastewater had percolated into the sand. The initial cleanup resulted in the affected areas being reopened to the public.

On February 1, 2006, The Districts initiated discussions with DHS and several scientists experienced in bacteria monitoring of soils and other experts in public health to develop a methodology for sanitizing affected sand areas. There were no known existing protocols to do this work, but ultimately The Districts developed a work plan to pilot test several approaches to sand sanitation.

The pilot tests were conducted at the 21st Street Manhattan Beach location on February 3 and 5, 2006, and consisted of evaluating the effectiveness of applying a dilute bleach solution to the sand, along with air drying, to restore the sand to its original condition to a depth of 3 feet. This target depth was agreed by all involved in the study to provide a sufficient barrier for the protection of public health during beach recreating activities, including recreational digging in the sand. The Districts established an on-site laboratory to conduct real-time analysis to aid in optimizing the application of the dilute beach solution to the 3 foot depth during the pilot test.

After extensive testing it was found that the use of the dilute bleach along with drying was successful in sanitizing the sand. It could be applied quickly, was proved to be effective for inactive bacteria, was safe to handle and could be controlled during the application process, and therefore did not pose a threat to the environment.

Based upon its sand clean-up experience, The Districts initiated a statewide review of sanitizing protocols utilized. To facilitate the statewide review, The Districts sponsored a workshop on June 14, 2006 to provide a forum to review protocols and implementation procedures in a Draft Spill Contingency Plan. This Plan's final draft was submitted to the Regional Water Board on July 5, 2006. Since then, The Districts have been requested by both State and National regulatory public groups focused on clean beaches to share the final Draft Spill Contingency Plan.

REVIEW OF THE SETTLEMENT AGREEMENT BETWEEN THE LOS ANGELES COUNTY SANITATION DISTRICTS, (The Districts), among others, AND THE LOS ANGELES REGIONAL WATER QUALITY CONTROL BOARD, (The Board), among others, COVERING SEWAGE OVERFLOWS FROM JANUARY 1, 2001 THROUGH SEPTEMBER 30, 2006.

DETAILS:

1. On July 14, 2006, The Board sought to impose a civil liability fine of $4,671,318 upon The Districts for a raw sewage overflow incident occurring in the South Bay Cities Main Pumping Plant on January 15-16, 2006. The Board further identified 92 other overflows of varying degrees of severity from locally and regionally-owned facilities of The Districts which potentially could have resulted in further civil liability assessments under existing Statutes of Limitation regarding such matters.

2. The Districts were ultimately able to craft a settlement proposal acceptable to The Board and other interested parties which was officially approved on December 14, 2006.

3. The essential terms of the Settlement provide that The Districts will pay, in exchange for a Release of all claims for penalties and injunctive relief arising out of all 93 overflows, a penalty in the sum of $2,500,000, distributed as indicated below:

    a. $125,000, payable to the California State Water Resources Control Board Cleanup And Abatement Account;

b. $2,200,000, payable to the Watershed Conservation Authority toward the construction and development of an educational facility known as the San Gabriel River Discovery Center at Whittier Narrows;

c. $50,000 to Kids Lead LA –Watershed And Marine Education Outreach Program; and

d. $125,000 toward the development of a Model Program for Bacterial Source Identification and Abatement Plan, to be undertaken by The Districts. This plan will include the design and development of identification methods and the implementation of a source identification study to determine fecal bacteria sources for beaches adjacent to the Redondo Beach Pier as part of its Pilot Project. Once such sources are identified, The Districts will apply any unused funds to the development of a source abatement plan, and secondly, to undertake additional source identification efforts within the South Bay environs.

4. Apart from the above monetary distributions, The Districts will further provide in-kind services valued at $200,000 toward the development of the Model Program for Bacterial Source Identification and Abatement Plan for the Redondo Beach Pier Project.

COMMENTARY RE SETTLEMENT PROVISIONS

1. As indicated by the above Settlement terms, the initially proposed monetary liability assessment was reduced from $4,671,318 to $2,500,000, a savings to The Districts and the taxpayers of $2,171,318.

2. It should be noted that only $125,000 of the Settlement total will actually leave Los Angeles County, payable directly to and earmarked for the California State Water Resources Control Board Cleanup and Abatement Account.

3. The balance of the payout funds are to be used locally to provide more direct benefits at the grass roots level, namely:

    a. The bulk of the funds, or $2,200,000, will be used to develop a Discovery Center located virtually in the heart of The Districts which is planned to provide educational programs and possible recruiting venues for young persons interested in environmental engineering careers, both of which have the potential to become major County-wide community assets.
    b. The $50,000 earmarked for the Kids Lead LA – Watershed and Marine Education Program will also help provide educational services which will ultimately serve the County as well.
    c. The $125,000 to be utilized in developing a Model Program for Bacterial Source Identification and Abatement Plan will only add to resolving the long term health and environmental concerns of the County.

4. Lastly, the in-kind Districts' services valued at $200,000 for the development of the Model Program for Bacterial Source Identification and Abatement Plan will greatly enhance the County's capacity to deal with the subject-matter of that project, and the expertise demonstrated by The Districts' personnel in dealing with this Program bodes well for its future.

DESCRIPTION OF THE PROPOSED SAN GABRIEL RIVER DISCOVERY CENTER-ITS PURPOSES, OPERATION AND OBJECTIVES

The San Gabriel River Discovery Center is a proposed education facility to be located within the Whittier Narrows Basin Natural Area in Los Angeles County. By locating the Discovery Center at the Nature Center in Whittier Narrows Park, which is already the County's most visited park with 1.4 million visitors annually, a seamless connection is already provided between the indoor exhibits and outdoor locations where classroom activity can be observed in a natural setting. The Governing Board of the proposed Discovery Center is a Joint Powers Authority (JPA) formed in January 2006, comprising 29 prominent individuals and entities.

Proposed Discovery Center

The purpose of this proposed facility, among other undertakings, is as follows:

a. To increase public knowledge of environmental issues involving the San Gabriel River, including its rich natural history and the importance of natural habitat preservation and restoration;
b. To increase public awareness of the rich and vibrant history of the San Gabriel River and its important role in the social and economic development of communities along its water course;
c. To raise public awareness of the importance of conserving and protecting ground water resources in the main San Gabriel and central ground water Basins;
d. To raise capital for the planning, design, development, construction and operation of the Discovery Center;
e. To generate public and institutional interest and support for the ongoing operation of the Discovery Center;
f. To harness the vision, insight and creativity of other civic-minded public and private organizations for the development of exceptional, informative and inspiring educational displays and programs; and
g. To identify, procure and secure reliable long-term funding sources for ongoing operations and maintenance of the Discovery Center.

Other relevant data for the Discovery Center Enterprise is as follows:

a. The JPA has developed a strong network of supporting organizations and actively seeks additional supporters. Notably, The Districts have contributed $100,000 thus far;
b. The estimated project cost in 2009 dollars is $27 million, to be funded from federal, state and local grants, private corporations, foundations and green building product incentives;
c. The Discovery Center will provide exhibits telling a comprehensive story about the San Gabriel Watershed;
d. Through the use of the Whittier Narrows Nature Center grounds, the message of the exhibits will be illustrated by physical examples in the outdoor setting.
e. The facility and grounds will incorporate and illustrate sustainable design practices, and plans to obtain a platinum rating in U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED) system: and
f. The Discovery Center will seek to expand the school user base to attract classes from a wider region in addition to area residents, visitors, civic leaders and organizations, and will provide meeting spaces for the region including a 150-seat multi-purpose room, reference library and 2 classrooms.

FINDINGS

The results of the Civil Grand Jury investigation and collateral inquiries generated the following findings:

1. That the prime cause(s) of the overflow of January 15, 2006 came about due to the malfunctions of circuitry which were beyond the control of and not included within the maintenance programs of The Districts.

2. That The Districts' responses to the overflow situation were timely, effective, competent and innovative, and in the process developed new protocols in beach sanitation treatment which are currently available to other local, state and federal agencies.

3. That the proposed major financial liability assessment of almost $4.7 million against The Districts was unreasonable, and not fully justified under the circumstances, which eventually resulted in a greatly reduced Settlement assessment which by its terms retained the vast bulk of the ultimate payment amount for uses and purposes located within Los Angeles County.

4. That the Settlement also precluded liability assessments against The Districts in 92 other potential overflow cases.

5. That the Management and Staff of The Districts at all times relevant to the primary matter under investigation acted professionally, promptly, in a scientifically visionary manner, and are deserving of the highest approbation.

RECOMMENDATIONS WITH RESPECT TO THE FINAL REPORT ON THE LOS ANGELES COUNTY SANITATION DISTRICTS

The 2006-2007 Los Angeles County Civil Grand Jury believes that these recommendations may well add to the future performance of The Sanitation Districts' long term mission:

1. After touring some of The Districts' local facilities, it became quite apparent that the key people interviewed were effectively accomplishing their assigned tasks, and in fact were most impressive. In a word, the leadership was outstanding. It also became clear that the Jury was looking at a public service enterprise which of necessity would only grow larger with the passage of time and the demands of an ever-expanding population. In this regard, and also in view of impending retirements, the Jury considered ways and means of enhancing the Staff at its lower levels with qualified people coming out of the educational systems in the County and elsewhere. The recommendation, therefore, is for The Districts to encourage the pursuit of environmental engineering careers by students by offering scholarships and fellowships to promising young people. The Jury understands there may already exist some activity along such lines, but the time seems right for the expansion of such a program.

2. The proposed Discovery Center is seen to be an excellent educational asset, and in view of the indications that it will be used to educate the public and students in class outings which visit the Center, the recommendation is that the location be utilized as a recruiting venue for visitors, with scholarship and/or fellowship applications available on site.

3. With regard to the proposed Discovery Center and its intent to seek to expand the school user base to attract school classes from a wider region, the recommendation is that broadside invitations to visit the facility should be circulated throughout educational institutions in as wide an area as feasible which would be likely to develop interest and professional participation in an environmental engineering career.

4. In terms of recruitment of environmental engineers, a Speakers Bureau for The Districts is recommended for the purpose of going out into the community, and to educational institutions in particular, in order to carry the message for this particular career field.

5. If funding for scholarships, fellowships, speakers and recruiters is not in the blueprint for the Discovery Center, it is recommended that a Foundation be created from among those institutions and individuals concerned with its purpose and operations to develop ways and means of securing such funding as an ongoing effort on behalf of the Center.

CONCLUSION

The Civil Grand Jury determined that what had initially been portrayed to the general public through the press and internet media as a major disaster for Los Angeles County and its taxpayers has ultimately transitioned into a highly beneficial result for the County in many respects, not the least of

which will be the operation and maintenance of the Discovery Center as herein described, and a real asset for the County. These results were essentially brought about through the skill, constructive suggestions and imaginative solutions contributed and supported by and through the efforts of the County Of Los Angeles Sanitation Districts and the highly efficient and motivated management and engineering personnel involved in its day to day operations.

GLOSSARY OF ABBREVIATIONS USED IN REPORT

DHS – County Department of Health Services
Districts – The Los Angeles County Sanitation Districts
E/I – Mechanics and Electrical/Instrumentation
JPA – Joint Powers Authority
JWPCP – Joint Water Pollution Control Plant
LBMPP – Long Beach Main Pumping Plant
LEED – U.S. Green Building Council's Leadership in Energy & Environmental Design
mgd – million gallons per day
PLC – Programmable Logic Controller
PM – Preventative Maintenance Program and Work Order System
SBCMPP – South Bay Cities Main Pumping Plant
The Board – Los Angeles Regional Water Quality Control Board
The Districts – Sanitation Districts of Los Angeles County
tpd – tons per day
UPS – Uninterruptible Power Supply

Solar and Alternative Energy

An Idea Whose Time Has Come

Solar Committee

James Corbett Tasker, Chair

Emilie Anselmo
Stuart L. Chason
Carole Greene
John Hackney
Lloyd Thornhill
Linda F. Winfield

A Report by an Investigative Committee of the Los Angeles County 2006-2007 Civil Grand Jury

SOLAR AND ALTERNATIVE ENERGY
"AN IDEA WHOSE TIME HAS COME"

EXECUTIVE SUMMARY

The majority of cities in the greater Los Angeles area participated in our solar and alternative energy survey. A handful of cities have actually installed solar energy devices on city owned facilities and equipment. The cities which have solar devices already in place have programs and people dedicated to reducing their dependence on the power grid.

Currently there is a wide variety of renewable energy products on the market that can be purchased and installed by the homeowner or by a contractor. Scaled down versions of windmills and roof mounted solar water heating systems are only a few of the new products available.

The state legislature has mandated a focus on new and renewable sources of energy. The time table for accomplishing this task is approximately within the next ten years. Our major energy suppliers are investing in the future to bring us energy from a wide variety of sources. Alternative energy will eventually account for the major source of our energy as we rely less and less on coal and other sources of CO2.

Conservation will play a major role in the future of our energy management. The County of Los Angeles has embarked on a County-wide program to reduce their power consumption by 20% on existing facilities, in accord with the Board of Supervisor's January 16, 2007 Resolution.

HISTORY

Carbon dioxide (CO2) emissions and fine particle emissions from fossil fuel electrical power generation are toxic to human health and constitute a serious public health problem. It is estimated that over thirty thousand Americans die annually as result of these emissions.

A January 2007 California Air Resources Board (ARB) report on the results of recent studies examining the health effects of air pollution included the finding that an estimated 5,400 residents in Southern California die prematurely each year due to air pollution. Solar and other renewable alternative and clean sources of electrical energy can now supply much of our electrical power needs with currently available technology.

California has long been concerned with the need for increased usage of renewable energy. In 2002, the Renewable Portfolio Standard Program had the goal of increasing the percentage of renewable energy in the State of California electricity mix to 20% by 2017. The Energy Commission's 2003 Integrated Energy Policy Report recommended accelerating to 2010, and the 2004 Energy Report

Update further recommended increasing the target to 33% by 2020. The State of California's Energy Action Plan supported this goal.
There are current incentive plans to meet these goals. For example, for 2006 Southern California Edison Company was allotted $121,050,000 for one time incentive payments to help reduce the cost of installing self generation equipment. About one-third of these funds are for solar installations. The rate is around $2.80 per Watt.

In August 2006 Senate Bill 1 was passed, increasing the commitment of the State of California to solar technology as one available means of alternative energy. This document states," It is the intent of the State to install solar energy systems with a generation capacity equivalent of 3000 megawatts, to establish a self sufficient solar industry in which solar energy systems are a viable mainstream option for both homes and businesses in ten years, and place solar energy on 50% of new homes in 13 years.

The Bill provides for $784,000,000 for locally owned public utilities for incentives to install solar systems in their jurisdictions starting in 2008. Municipalities in Los Angeles County were polled as to their plans for these incentives.

SOLAR AND ALTERNATIVE POWER INVESTIGATION PURPOSE

The purpose of this investigation at the outset was to assess the extent of the City of Los Angeles' Department of Water and Power (DWP) implementation of its solar plan as expressed in its 2003-2004 annual report. This plan was delineated under the title Renewable Portfolio Standard, Solar Programs. In part it stated "we are working with City Departments to install solar energy systems on libraries, police stations, animal service centers and other municipal buildings." It further expressed that these would be "showcases" of the technology. Our purpose was to determine if the DWP plan is being implemented, and if it is considered a success.

We also polled the other eighty-seven (87) cities within the county, as models for their respective communities, to see if they are taking advantage of incentive programs for use of renewable energy installations and encouraging others in their jurisdiction to consider this option in implementation of State of California Senate Bill No. 1. Lastly, the policies and practices of the County itself were examined with respect to alternative energies and conservation measures.

METHODOLOGY

The Alternative Energy Project was comprised of several major tasks. A brief description of each task and how that task was completed follows:

I. Documentation of Progress of Implementation Department of Water and Power Renewable Portfolio Standard, Solar Programs:

The Solar Program administrator for Los Angeles Department of Water and Power was invited to address the Civil Grand Jury. Two follow up interviews were conducted to obtain additional information on the Renewable Portfolio standard, Solar Photovoltaic Incentive Program, and Solar

Installation Program, and to obtain a listing of municipal buildings using solar energy. The progress of this program is described in the subsequent section.

II. Survey of Solar/Alternative Energy

A survey was designed and sent to eighty-eight (88) municipalities in Los Angeles County. The purpose was to obtain baseline information concerning the degree to which solar and alternative energy has been considered, and to identify barriers to the adoption of these cleaner technologies.

The survey was field tested in a randomly chosen municipality outside of Los Angeles County to ensure that questions could be clearly understood and addressed by the intended recipients. Names and addresses of the mayor of each selected city were obtained from Los Angeles County Website "Roster of City Officials, dated 1/3/07 < http://cao.lacounty.gov/forms/cityoff.pdf>. Original letters were sent in October of 2006, with follow-up phone calls and faxes in December, 2006, February 2007, March 2007, and May 2007. The final overall response rate of the 88 cities was 100 %.

Survey responses were analyzed to discern significant trends in implementing solar and alternative energy within the cities. Responses of significant interest given by specific cities are reported in the findings. Other responses to survey questions were categorized according to cities with populations 50,000 or less or greater than 50,000 (Los Angeles County website: Source: California Department of Finance, January 2006).

III. Site visits

Members of the Civil Grand Jury visited the installation of Solar panels at the Department of Water and Power located at the John Ferraro Building, 111 N. Hope Street, Los Angeles, in October 2006.

Members attended a meeting of the Southern California Public Power Authority in Pasadena in March 2006 to obtain an overview and to gain city-specific information regarding joint powers agency structure and operations.

Members attended the UCLA Energy Forum Speaker Series "Leading by Example: California's Aggressive Energy Goals" November 29, 2006, UCLA Anderson School of Management.

Members attended California Science Center Solar and other exhibits, September 2006.

IV. Document Analysis

Several documents related to solar and alternative energy were used as background for the investigation. These documents included:
Senate Bill 1, http://www.gosolarcalifornia.ca.gov/ -
City of Los Angeles Department of Water and Power (DWP) 2003-2004 Annual Report.
Department of Water and Power Solar Photovoltaic Incentive Program Guidelines, July 25, 2006
Million Solar Roofs Goes up" <www.lacitybeat.com/article 8/24/2006>
"Clean Energy: A giant step toward a Million Solar Roofs" Environment California www.environmentcalifornia.org

A more complete list of references can be found in the Bibliography.

FINDINGS

Solar Survey Qualitative Responses

Solar and alternative energy varies across the 88 municipalities with respect to level of awareness, technology, and economic status. There are a variety of options for using renewable energy as a supplemental source of electricity supply.

There are cities which use solar energy for such purposes as message boards, traffic beacons, and lighting systems. Other municipalities encourage passive use of solar in tree planting, water heaters and swimming pools or in commercial installations.

Several cities report combining solar and other sources of renewable energy to supplement the generation of power for a water treatment plant or a parking structure, and are encouraging and/or incorporating "green" and sustainable design principles in commercial and residential building projects.

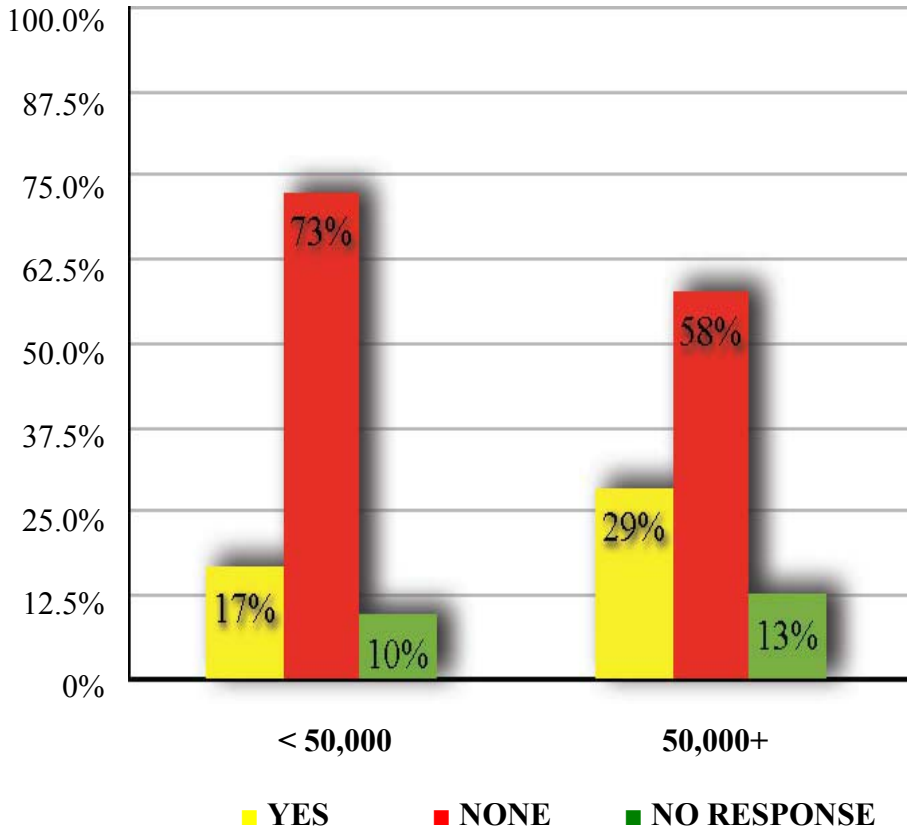
The responses from the 88 cities are based on self report, and have been taken from the completed survey forms submitted by the respective cities. Select data has been excerpted from the responses submitted by the 88 municipalities within the County of Los Angeles, and is set forth on three bar graphs included in this report.

Specific subject matter reflected in the three bar graphs includes cities reporting using solar power for structures (Graph 1), city responses as to whether there is an individual or department responsible for solar energy (Graph 2) and the individual cities responses as to whether they have future plans for using solar energy (Graph 3).

Using Solar Power for Structures

City responses to whether their municipality has facilities which use solar energy indicated that those with a population of 50,000 or more tended to respond yes to this item as compared to smaller cities (29% vs. 17%). Those cities that responded to our survey; but that did not list a response; *i.e., no response category,* were similar for smaller and larger cities. This information is shown in Graph 1.

Graph 1: Cities responses to whether there are facilities which use solar energy.

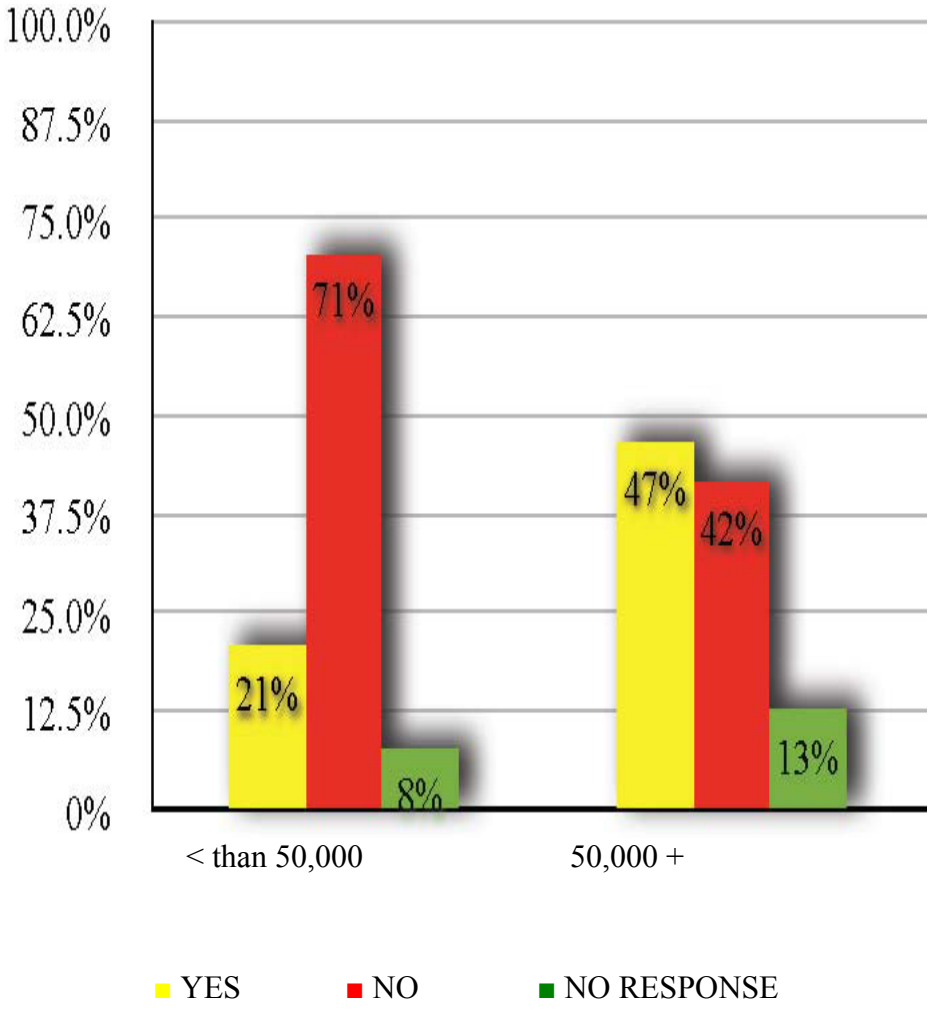


Question 1 Total Number of Responses

Population	Yes	No	No Response	Total
<50,000	8	35	5	48
50,000+	11	22	5	38

Similarly, larger cities also tended to have a specific individual or department responsible for solar energy (47% vs. 21%). The percentage of cities that did not indicate a response on their survey was similar for larger and smaller cities, as indicated in Graph 2 below.

Graph 2: Cities responses to whether there is an individual or department responsible for solar energy



Question 2 Total Number of Responses

Population	Yes	No	No Response	Total
<50,000	10	34	4	48
50,000+	18	16	4	38

Some Cities Using Solar (photovoltaic) Power for Structures:

Azusa- Solar energy is used in the Light and Water's Administration Building. The cost of this installation was contributed to by Air Quality Management District. The efficiency of this installation was not as high as expected. Azusa light and water provides grants for solar installations. They plan to install solar power on a new water treatment plant, Azusa Light and Water also uses 6% wind power. Azusa Water and Power intends to have 20% alternative or renewable sources by 2010.

Cerritos- City Hall and the Swim Center uses solar energy. It has not been cost effective at City Hall, but the City has experienced savings at the swim center. The City has adopted a policy of having 20% renewable energy by 2010, and is reviewing plans for using alternative sources of energy in the future.

Glendale- This City offers a rebate program for both residential and small business customers. Glendale's small business program is new this year and they have received many inquiries. The City has provided funding to install a photovoltaic system on Glendale City College Science Center, and provided funding to install grid-connected, net-metered systems on local Habitat for Humanity homes. Seven of these systems have been installed since 2002.

The City is currently evaluating a joint project that could result in photovoltaic installation on the new Glendale City parking structure. If completed, the system would be owned and operated by Glendale Water and Power and all power generated would feed into the grid for resale. Glendale Water and Power is providing the City of Glendale energy from several renewable sources including landfill, wind, photovoltaic and geothermal, with a projected goal of over 20%-23%(from the current 14%) by 2017.

Long Beach- Buildings with solar energy are South East Resource Recovery Facility trash to energy plant (SERRF), Belmont Shore Fire Station, and Long Beach Convention Center. The solar panels provide less then the buildings require, and less then projected when installed. Planning and Building has a sustainability program and larger projects must be LEED (Leadership in Energy and Environmental Design) Certified.

Los Angeles- CGJ inquiry determined that the Department of Water and Power (DWP) has been implementing their 2003-2004 plan to install solar energy systems to provide power to the City's buildings, including libraries, police stations, and other. Periodically, projects (a "wish list") are presented to DWP by City departments for possible installation of solar energy systems. A feasibility study is done to select the best candidates. Special consideration is given projects of 7500 square feet or greater, as they must meet standards of the United States Green Council (LEED certified).

Final approval of these projects is made by the DWP board. Installation is done by the DWP. DWP maintains the systems. The energy is metered and monitored by DWP. Extra energy produced goes to the power grid. Since DWP and the Department both belong to the City, no money changes hands.

The following facilities have been provided with solar power under this City of Los Angeles DWP program:

Sun Valley Library; 7935 Vineland Ave.
Lakeview Terrace Library, 12002 Osbourne St.
Hyde Park Library, 2205 W. Florence Ave.
Canoga Park Library, 20939 Sherman Way.
Ascot Library, 120 W. Florence Ave.
Los Angeles Convention Center 1201 Figueroa St.
Los Angeles Convention Center 1301 Figueroa St.
Main Office DWP 111 N. Hope St. (upper level parking)
Main St. Bldg. 9, 1630 Main St.
Council member Ruth Galanter District 6 Field Office 7166 W. Manchester Ave.
Van Nuys Service Center, Tool-room Bldg. 7501 Tyrone Ave.
Ducommon Fitness Center 433 E. Temple St.
West Valley Water District, 18144 Devonshire St.
Truesdale Center, 11760 Truesdale St.
Distribution Facility 3, 708 Regan St.
North Central Animal Services, 3201 Lacy St.

The Survey which was sent to all cities in the County had the following responses by L. A. City: The solar panels in general provided the required amount of energy, but were not cost effective, compared to the average retail rate. Respondents felt that with improved technology, use in the future may meet expectations. Use of solar power is encouraged through the DWP Solar Power Incentive program. The DWP Public Benefits Program provides funds for the installation of solar panels on City structures. There are numerous projects in development and the City will continue to offer rebates for City agencies to install solar photovoltaic panels.

Besides Solar, the city utilizes energy from alternate sources such as Wind 1%, Biomass1%, Fuel Cells 1%, and small Hydro 4%. All City facilities use DWP electricity with 6% renewable energy. This percentage will increase to 20% by 2010. DWP offers a voluntary renewable energy program- Green Power for a Green L. A. to all customers, and a Customer Generation Rebate Program to encourage customers to install renewable or fuel cell generation.

Pasadena-This City found solar panels to be cost effective when subsidized by Pasadena Water and Power(PWP). Funds were provided by the State of California. These panels are on the Lamanda Park Library. PWP also provides incentives to individuals and businesses to use solar and other alternate sources of energy. There is a PWP warehouse planned with solar power. Other alternate sources of energy include wind and geothermal. Wind energy is at 5%. The City Council adopted a renewable portfolio standard (RPS) with a goal of 10% renewable energy by 2010, and 20% by 2017.

Santa Clarita-This City recently installed solar power on a transit maintenance facility. It is too early to tell the effectiveness of this installation, but so far the impression is positive (with reservations - does not appear to produce the energy expected). The City uses this installation as a "green" building demonstration project to encourage "green" building workshops and other educational programs. The City is considering participation in "Go Solar", and is considering a private sector "green" building incentive program. The City is also considering hydrogen fuel cells for fueling vehicles.

Santa Monica- This City reported that they have five structures using solar power. These are:

Colorado Court, Solarport, Main Library, Civic Parking Structure, and Airport Administration. The City expects simple payback within 15-20 years, and has had an excellent experience with solar power. The City provides information to the general public through the "Solar Santa Monica Program". The City purchases 100% renewable energy for 100% of load for City buildings. The City gives sustainability high priority.

Some Cities Using Solar Power for Lighting, Heating, Traffic Control, and other uses:

Burbank- This City uses Burbank Water and Power and has solar panels installed on a parking lot. These panels provide less power then is required They were installed as a R&D (Research and Development) project. Payback is projected at 15+ years, which is not cost effective. Tree growth and panel cleanliness must be managed. Rebates are offered, as well as workshops and information. Burbank is planning a solar system on their new parking area. Alternate forms of energy are used by the City, including wind, geothermal, landfill, and small hydro-electric.

El Segundo- This City experienced some maintenance problems with solar powered irrigation controllers, changeable message boards, and arrow boards. They are planning to install traffic beacons that are solar powered.

Lancaster- This City uses solar powered irrigation controllers for freeway landscaping, and is designing solar photovoltaic shade structures. The City is investigating a possible waste energy plant project and is also planning a bio-diesel production facility.

Manhattan Beach- This City had a professional assessment done for solar use, and the area was found to be generally too overcast. The City has solar powered irrigation controls, message boards, and flashing yellow signals. 20% of the City's vehicle fleet uses either electricity or compressed natural gas.

Montebello- This City installed solar panels as part of their high capacity bus shelter project. The Solar panels provide the required amount of power hours for the shelters' lighting systems. The results of this program have been excellent. The City encourages the use of solar power by showing the general public the effectiveness of the lighting project. The Federal Government provided financial assistance. The City plans to use solar power for all new city owned high occupancy bus stops within the city limits.

Redondo Beach- This City has installed solar powered irrigation controller stations for various parks, parkettes, and landscaping medians. These installations are considered successful.

Sierra Madre- This City has a solar water heating system for its Municipal Swimming Pool. It has reduced costs meeting expectations. Funding was provided by AQMD, Southern California Gas, and from the County of Los Angeles.

West Covina- Several traffic devices have been installed. The City is evaluating the installation of solar panels at City Hall. Renewable energy from the BKK landfill gases is provided to the City via SCE.

Whittier- The City has several traffic devices powered by solar. The State has provided some funds for these. In the future some parking lot lights may run on solar energy. Four vehicles use compressed natural gas. A compressed natural gas station is planned

Cities That Use Alternate Forms of Energy Including Compressed Natural Gas in Vehicles

Claremont- The City has encouraged and is encouraging the use of solar power. The City is currently considering installing solar panels on a multi-model transit station in historic downtown. The City is also considering a policy that would require future City facilities to be constructed to LEED Silver or higher LEED certification levels. Claremont also has a Compressed Natural Gas (CNG) refueling station and uses this fuel in many vehicles. Claremont is currently working on a plan that would encourage the use of alternate sources of energy by private individuals and businesses.

Industry- This City has a gas fired engine generator which uses 50% landfill gas to provide power for a resort owned by the City. The City's electrical utility has a Memorandum of Understanding for wind generated energy purchasing.

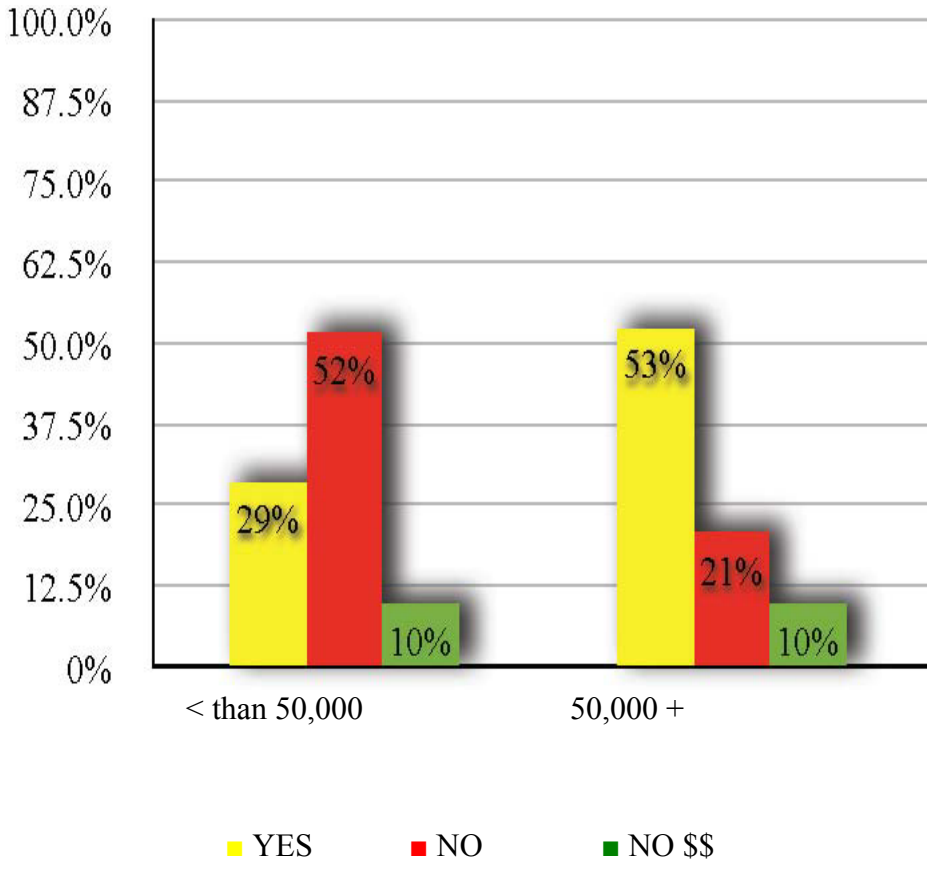
Monterey Park- This City uses cogeneration to both heat the municipal swimming pool and to power the pool's facilities. This process uses natural gas, and has been highly effective. Through cogeneration, some of the energy is converted to electricity in addition to heat.

San Gabriel- This City has adopted a plan for its Valley Boulevard Corridor for sustainable design; use of solar, or other alternative source is encouraged and may result in fee reductions. Compressed natural gas is used in appropriate City vehicles. The City is considering the feasibility of a new "green" City yard based on sustainable design principles including the possible use of solar energy.

Some cities that encourage businesses and individuals to use solar or other alternative energy sources (some have ordinances requiring "green" construction) include Agoura Hills, Avalon, Calabasas, Downey, and Palmdale.

According to our survey, more than 50% of the larger cities indicated they planned to use solar energy in the future. Approximately a third of the smaller cities indicated future plans. Of those that responded no, ten percent indicated that their use of solar energy depended on financial issues of cost and cost effectiveness. These results are depicted in Graph 3. *(Note: those that did not indicate a response on the survey were 8% for the smaller and 15% for the larger facilities).*

Graph 3: Cities responses to whether they have future plans for using solar energy.



Question 11 Total Number of Responses

Population	Yes	No	No $$$	No Response	Total
<50,000	14	25	5	4	48
50,000+	20	8	4	6	38

Some other cities that are considering the use of solar or alternative energy include Avalon, Calabasas, Downey, El Segundo, Gardena, Hermosa Beach, La Habra, Lakewood, La Puente, Lynwood, Palmdale, San Fernando, Santa Fe Springs, South El Monte and West Hollywood.

Alternative Energy Overview

The need for alternative energy has been debated both nationally and internationally for well over the past two decades. After much debate the State of California Legislature has pointed the way with Senate Bill 107 and Assembly Bill AB 200.

Energy Providers

Within the Southern California area, we have a mix of electrical energy providers. Southern California Edison is by far the largest, selling energy to its customers per regulations set by the Public Utilities Commission. At the present time there is at least one major joint powers agreement between twelve cities and one irrigation district which includes the City of Los Angeles Department of Water and Power. These Energy Providers buy in to existing and new energy sources to meet their state mandated power mix. A handful of cities in Los Angeles County generate power for resale. They are members of the Joint Powers agreement and benefit by purchasing low cost electricity.

Alternative Energy Generation

Alternative energy can best be defined as energy not being provided from existing sources but capable of being part of the Power Mix. The sources are numerous, offering optimism to the search for reliable clean energy. Some are already developed and some will require further development before they become reliable enough to be counted in the Power Mix.

State Mandate for Change

The green house effect and related discharge of CO2 into our atmosphere has caused our energy providers to focus on reliable, new, renewable, low cost sources of clean energy. We have all been aware that the day would arrive when we would be required to reduce green house gasses and become more energy efficient. Both the California Senate bill 107 and the Assembly measure mandate a significant reduction in the use of coal and other CO2 sources by the year 2017.

The Challenge Ahead

The California state plan requires 2500 MW of power. This is a very aggressive plan. Energy providers such as Southern California Edison say they cannot guarantee that they will meet the required plan after 2008. Southern California Edison states their best estimate at 1,500 -2000 MW of power. At issue is the time required to bring new systems on line, and prove their reliability and to insure that they will be economically viable.

Solving the Problem, No Simple Fix

Natural gas will replace much of the coal burning generation currently in place. However our natural gas supply is not unlimited. Energy providers from across the nation have been busy buying "futures" on natural gas production. New gas fields will need to be developed before production can begin. Many of these new fields will require pipe lines and distribution networks a considerable distance from existing lines.

Mid to Long-term Planning

As our current supply is depleted, we will be required to shift from natural gas to other reliable sources. Solving the problem will require a major investment on the part of our energy providers. A new technology for coal may result in a clean system. Coal may be the source to produce Hydrogen (H2), which will be used as a fuel and CO2 as a byproduct which will be used to produce more fuel. It is obvious that new and renewable and conventional resources must provide for much of our energy needs.

Power Content Labels

California law requires all energy providers to furnish their electricity customers with a power content label which gives the customers information about the energy sources used to generate the electricity that is provided them. A recent City of Los Angeles Department of Water and Power (DWP) power content label example may be viewed on the page immediately following.

2007 POWER CONTENT LABEL

Second Quarter

ENERGY RESOURCES	LADWP Power* (projected)	LADWP Green Power** (projected)	2005 CA POWER Mix*** (for comparison)
Eligible Renewable**	8%	100%	5%
-Biomass & waste	1%	-	<1%
-Geothermal	<1%	-	4%
-Small hydroelectric	6%	25%	1%
-Solar	<1%	-	<1%
-Wind	1%	75%	<1%
Coal	47%	-	38%
Large Hydroelectric	7%	-	24%
Natural Gas	29%	-	33%
Nuclear	9%	-	0%
Other	<1%	-	0%
TOTAL	100%	100%	100%

* 88% of **LADWP Power** is specifically purchased from individual suppliers.

** 100% of **LADWP Green Power** is specifically purchased from individual suppliers.

*** Percentages are estimated annually by the California Energy Commission based on the electricity sold to California consumers during the previous year.

**** In accordance with Los Angeles City Council's action on 10-5-04 for File No. 03-2688 (RPS).

For specific information about this electricity product, contact LADWP at 1-800-DIAL-DWP. For general information about the Power Content Label, contact the California Energy Commission at 1-800-555-7794 or www.energy.ca.gov/consumer.

2006 POWER CONTENT LABEL

Annual Report of Actual Electricity Purchases for LADWP Calendar Year 2005

ENERGY RESOURCES	LADWP Power* ACTUAL MIX	LADWP Power PROJECTED MIX	LADWP Green Power** ACTUAL MIX	LADWP Green Power PROJECTED MIX	2005 CA POWER MIX*** (for comparison)
Eligible Renewable	6%	5%	100%	100%	5%
– Biomass & waste	1%	1%	<1%	<1%	<1%
– Geothermal	<1%	<1%	<1%	<1%	4%
– Small hydroelectric	5%	3%	13%	<1%	1%
– Solar	<1%	<1%	<1%	<1%	<1%
– Wind	<1%	1%	87%	100%	<1%
Coal	51%	53%	-	-	38%
Large Hydroelectric	5%	6%	-	-	24%
Natural Gas	29%	26%	-	-	33%
Nuclear	9%	10%	-	-	0%
Other	<1%	<1%	-	-	0%
TOTAL	100%	100%	100%	100%	100%

* 90% of **LADWP Power** is specifically purchased from individual suppliers.

** 100% of **LADWP Green Power** is specifically purchased from individual suppliers.

*** Percentages are estimated annually by the California Energy Commission based on the electricity sold to California consumers during the previous year.

**** In accordance with Los Angeles City Council's action on 10-5-04 for File No. 03-2688 (RPS).

For specific information about this electricity product, contact LADWP at 1-800-DIAL-DWP. For general information about the Power Content Label, contact the California Energy Commission at 1-800-555-7794 or www.energy.ca.gov/consumer.

1.5 million (Rev. 6/06)

County of Los Angeles

On January 16, 2007, the County of Los Angeles Board of Supervisors adopted the U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED) standard. Under this program, the Department of Public Works will review each of the County's Capital Programs to determine the feasibility of incorporating sustainable design features within the respective programs.

A major focus of this review will be on conservation. In December of 2006, the Department of Public Works and Regional Planning instructed the Director of the Internal Services Department (ISD) to establish and to chair the Los Angeles County Energy and environmental team, which shall:

- Develop recommendations for energy conservation and environmental initiatives for approval by the Board of Supervisors.

- Implement and monitor the Board of Supervisors' approved targets for reduction of energy usage Countywide.

- Provide regular reports on status of energy programs to the Board of Supervisors and the public.

- Join the California Climate Registry to assist the County in establishing goals for reduction of Green House gasses.

- Approve the Sustainable Design Program for Countywide capital improvement and refurbishment projects.

The County has over sixty million square feet of existing office and facility space. The County is the largest single customer of Southern California Edison. The County of Los Angeles is not a provider or reseller of energy. There is no individual County department responsible for all solar or other renewable alternative energy program areas.

The proposed Energy and Environmental Policy provides a structure for development of energy efficiency. Solar and other renewable power will also be a key element of achieving LEED certification for certain types of new and existing buildings.

The Energy and Water Efficiency Program conservation program seeks to further reduce County facilities energy and water consumption. The Environmental Stewardship Program is designed to measure the County's "environmental footprint", including minimization of air pollutants.

The County's Internal Services Division/Energy Management Department recognizes most other local governments and public agencies and constituents within the County have limited knowledge on energy issues. The Public Outreach program will utilize the County's communication and outreach channels to share information with the utility industry, as well as facilitate implementation of subsidy and assistance programs.

The Sustainable Design Program provides for the integration of sustainable "green building" technologies into the County's capital improvement and refurbishment projects. The Sustainable Component will encompass projects that can feasibly incorporate appropriate Design Components. In addition, some projects such as the County Data Center will be eligible for the LEED certification based on innovative design.

These proposed actions, and those already underway, support the County's Strategic Plan goals for Service Excellence, Organizational Effectiveness and Fiscal Responsibility. In the current budget, $5 million in one time funding has been approved for specific energy related projects. The total fiscal impact and source of funding for total implementation in accordance with the Board of Supervisor's January 16, 2007 Resolution is not known at this time.

With regard to cost and funding, the energy efficient programs that have been implemented by the County have been very effective and have returned substantial cost reductions to date. Many of the County facilities are forty to fifty years old and require major refurbishment. Because of the tremendous demand in existing County facilities for energy efficiency through traditional projects, this has not been a high priority.

The County has spent over $30 million in traditional energy projects since the mid 1990's and currently has realized total, cumulative savings of over $l00 million, evincing significant cost benefit of these ongoing efforts. The County's annual utility bills are over $l50 million per year ($l00 million in electricity and $50 million in natural gas costs).

Rising natural gas and electricity prices make effective implementation of cogeneration resources an important ongoing area of attention and study for the County. Cogeneration is thermodynamically the most efficient use of fuel. In separate production of electricity some energy must be rejected as waste heat, whereas in cogeneration the potential for production of high quality energy, in the form of electricity or work, is saved.

Cogeneration may be defined as the usage of a heat engine or a power station to simultaneously generate both electricity and useful heat. In a simple example, a car motor becomes a cogeneration plant in winter, when the rejected heat byproduct is useful for warming the interior of the vehicle.

The County operates large cogeneration facilities at Olive View Hospital and the Pitchess Detention Center, in addition to the Civic Center Cogeneration Plant. The Civic Center Cogeneration Plant serves heating and cooling needs of many large downtown facilities, including, among others, the Kenneth Hahn Hall of Administration, the Stanley Mosk Courthouse, the Clara Shortridge Foltz Criminal Justice Center, the County Hall of Records, the Dorothy Chandler Pavilion, the Los Angeles Music Center and the Walt Disney Concert Hall.

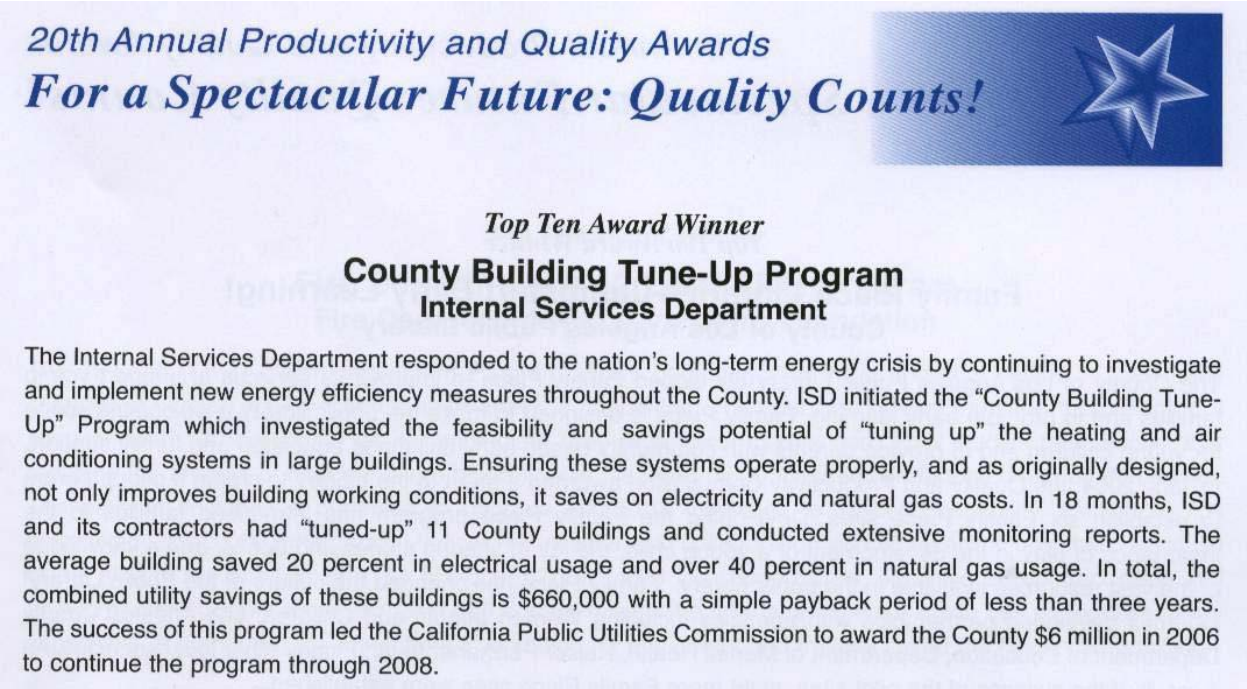
The County has developed an energy plan which includes all County departments. Other input and resources, such as Southern California Gas, Southern California Edison, and the City of Los Angeles Department of Water and Power, are also part of the planning process.

Working Together Towards a Spectacular Future: Practices and Policies

Under the County's newly adopted Energy & Environmental Policy, solar energy and other renewable resources will come under increasing scrutiny as components of the Policy's goal to:

- Certify new buildings of a certain size to LEED Silver-level eligibility;
- Reduce County energy consumption by 20% by 2017;
- Reduce greenhouse gas emissions the County is adjudged responsible for; and
- Develop a renewable energy strategy under the Policy.

The County's plans include all new construction, as well as the refurbishment of existing facilities such as has been underway. The new designs will contain energy efficient components. The refurbishment projects will continue to require time and funding resources.



20th Annual Productivity and Quality Awards

For a Spectacular Future: Quality Counts!

Top Ten Award Winner

County Building Tune-Up Program

Internal Services Department

The Internal Services Department responded to the nation's long-term energy crisis by continuing to investigate and implement new energy efficiency measures throughout the County. ISD initiated the "County Building Tune-Up" Program which investigated the feasibility and savings potential of "tuning up" the heating and air conditioning systems in large buildings. Ensuring these systems operate properly, and as originally designed, not only improves building working conditions, it saves on electricity and natural gas costs. In 18 months, ISD and its contractors had "tuned-up" 11 County buildings and conducted extensive monitoring reports. The average building saved 20 percent in electrical usage and over 40 percent in natural gas usage. In total, the combined utility savings of these buildings is $660,000 with a simple payback period of less than three years. The success of this program led the California Public Utilities Commission to award the County $6 million in 2006 to continue the program through 2008.

CONCLUSION

In the future, each of us will be participating in multiple forms of recycling and alternative energy. It will become part of our routine at home and at work. The need to reduce our dependence on coal and fossil fuel will eventually affect many more parts of our lives than are now evident.

Hybrid automobiles are now a reality. The design of new fuel cells may soon offer increasingly efficient and more affordable cost for transportation.

Public transportation will become even more of a priority to move people from the home to the work place. New buses may have solar cells as a part of their body structure.
`

The development of alternative energy sources will require each of us to conserve in many ways. Renewable, new, and passive technologies will be leading resources of alternative energy.

Conservation measures will be very, very important.

Appendix I –Foreman's Civil Grand Jury Cover Letter and Survey Instrument

County of Los Angeles
CIVIL GRAND JURY
CLARA SHORTRIDGE FOLTZ CRIMINAL JUSTICE CENTER
210 WEST TEMPLE STREET • ELEVENTH FLOOR • ROOM 11-506 • LOS ANGELES, CALIFORNIA 90012
TELEPHONE (213) 893-1047 • FAX (213) 229-2595
http://www.grandjury.co.la.ca.us/

October 18, 2006

We are the members of the 2006-2007 Los Angeles County Civil Grand Jury. One of our committees is interested in whether and how much solar and other alternative sources of energy are being used in your municipal buildings. This survey is very important to us. Feel free to use attachments to answer questions or provide additional information. Please complete this survey within two weeks of receipt and fax to (213) 229-2595 or mail it to us so that we can include it in our findings. We will be more than happy to discuss our survey or other matters related to alternate energy. Our contact person is Jim Tasker at (213) 893-1047.

Sincerely,

Robert E. Sax, Foreperson
2006-2007 Civil Grand Jury

Enclosure: Solar and Alternate Sources of Energy Survey, 3 pages

Solar and Alternative Sources of Energy Survey

A .Who is your energy supplier?

_____

B. Solar Energy

1. Please name the municipal buildings or facilities in your jurisdiction (and indicate their location) that use solar energy.

_____

_____

2. Is there an individual or department responsible for solar energy? If so, please provide name and telephone number.

_____

_____

3. Do the solar panels provide 1. less□ 2. the required amount□ or 3. more□ Kilowatt hours then the building or facility requires?

4. If the solar panels provide more energy than is required, does the energy go to the grid? How do you get credit for this?

_____

_____

5. Have your solar panels been cost effective? If so, How? To what extent are you experiencing the cost savings that may have been projected for the building when the solar panels were installed?

_____

_____

1

6. Does the output of the solar panels meet your expectations, or the expectations that were conveyed to you when the solar panels were installed? If not, please explain.

_____

_____

7. Are you receiving the amount of energy planned when the energy source was installed? Yes □ No □

8. In general, how would you rate your experience with solar power(1-poor, 5-excellent)

1. □ 2. □ 3. □ 4. □ 5. □

9. To what extent does your jurisdiction encourage the use of solar power by private individuals or businesses? Please explain.

_____

_____

10. Did your jurisdiction receive funding for the installation of solar panels? If so what source? 1. Edison 2. State of California 3. Other_____

11. Do you have current and/or future plans for using solar power? Please explain.

present_____

future_____

C. Alternate source of energy 1. Wind□ 2. Geothermal□ 3. Biomass□ 4. Fuel Cells□ 5. Other

1. Please describe any alternate renewable sources of energy you are currently using. What percent of your total energy comes from alternate sources?

_____

_____

2. Please name the buildings or facilities in your jurisdiction (and indicate their location) that use an alternate source of energy other than solar.

_____

_____

3. To what extent does your jurisdiction encourage the use of alternate sources of energy by private individuals or businesses? How?

_____

_____

4. Do you have current or future plans for using an alternate source of energy. Please explain?

_____

_____

Contact Person: Jim Tasker
Telephone: 213 893 1047

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Standing Committees

Audit Committee

Audit Committee Members

Walter Lappo, Chair

Bob George
John Hackney
James Corbett Tasker
Linda F. Winfield

A Report by a Standing Committee of Los Angeles County 2006-2007 Civil Grand Jury

AUDIT COMMITTEE FINAL REPORT

The Audit Committee assists Investigation Committees of the Civil Grand Jury when they require the work of audit firms. To provide this support for the 2006-2007 Jury, the Audit Committee

- interviewed interested audit firms early in the year to identify likely candidates for possible Jury use
- counseled Investigation Committees to determine if the use of an audit firm would be beneficial
- consulted with Investigation Committees to ensure that a clear and accurate statement of requirements would be developed
- interviewed appropriate candidate audit firms to solicit contract proposals
- reviewed contract proposals received from audit firms together with the Investigation Committees in order to determine the best selections
- assisted in getting contracts approved by the Committees, the Civil Grand Jury, the County Counsel and the Supervising Judge
- developed, with the Investigation Committees and audit firms, project project milestones and completion schedules
- monitored the progress of audit work to insure on time and satisfactory completion
- reviewed and approved all audit firms billings

During the 2006-2007 Civil Grand Jury session, the Audit Committee assisted three Investigation Committees working with two audit firms. The Investigations in each case resulted in approved reports received on schedule.

AUDIT COMMITTEE

Purpose

The Audit Committee is a Standing Committee created by each new Civil Grand Jury. Its functions are:

1. To hold initial interviews to identify a group of qualified and appropriate candidate audit firms so they can be subsequently considered, as needed, for possible audit projects in support of Investigation Committees that require certain professional expertise.

2. To advise and assist each Investigation Committee that does require the use of an audit firm in the preparation of a statement of project objectives, to be used by the candidate audit firms for developing project proposals.

3. To assist Investigation Committees by recommending, arranging, and participating in interviews with those audit firms determined to be best suited for use in a particular Investigation.

4. To assist the Investigation Committees in reviewing and approving the project proposals subsequently received from audit firms.

5. To assist the Investigation Committees in the process of getting approval of audit contracts by the Civil Grand Jury, by the County Counsel, and by the Supervising Judge.

6. To assist the Investigation Committees in monitoring the progress of audit firms in carrying out project plans, and to assist in resolving any problems in achieving correct and complete project results.

7. To approve billings from contracted audit firms as received and as consistent with project progress.

8. To update the Audit Committee section of the Civil Grand Jury Administrative Manual as appropriate based on the Jury's experience.

Citizen Complaints

Citizen Complains Committee Members

Richard Lorne Davis, Chair

Emilie Anselmo
Nola Burnett
Stuart L. Chason
Lewis Hastings
Charles Repp Jr.
John Visser
Ung Yol Yu

A Report by a Standing Committee of Los Angeles County 2006-2007 Civil Grand Jury

REPORT OF THE CITIZEN COMPLAINTS COMMITTEE OF THE 2006-2007 LOS ANGELES COUNTY CIVIL GRAND JURY

EXECUTIVE SUMMARY

The Citizen Complaints Committee is a Standing Committee of the County of Los Angeles Civil Grand Jury, and one which is mandated by State Law. Its primary and essential function is to responsibly provide, in strictest confidence, unbiased, independent evaluations regarding complaints submitted by individuals with respect to County and City Governments, Agencies and Special Districts within the County of Los Angeles over which the Grand Jury has oversight jurisdiction, and to recommend appropriate actions to be taken by the entire Grand Jury and ultimately by the concerned recipients of its Final Report.

Such oversight jurisdiction, however, does not include reviews of Judicial performance, Court actions (Civil or Criminal in nature), pending litigation, Federal or State functions, actions or personnel, or out-of-State matters.

Procedurally, during the period of its tenure, the Citizen Complaints Committee evaluates each individual complaint and determines whether any one of the following actions should be undertaken, namely:

1) That no action be taken;
2) That there is no Jurisdiction over the Complaint subject-matter;
3) That there be a referral of the Complaint to an appropriate committee for further investigation and recommendations; or
4) To undertake some other appropriate disposition of the Complaint.

Once the Citizen Complaints Committee as such has recommended a specific disposition of a particular Complaint, each case was then submitted to the entire Grand Jury for its review, evaluation and vote as to whether the Committee's preliminary recommendation should be approved, amended as appropriate, referred back to Committee, or to otherwise determine that some alternative course of action should be pursued.

At the conclusion of the Citizen Complaints Committee's activities during the term of its existence, a Final Report is prepared, summarizing the cumulative results of its assigned responsibilities, which Final Report delineates the methodology utilized, and is herewith submitted.

METHODOLOGY FOR PROCESSING CITIZEN COMPLAINTS

1. The Citizen Complaints Committee Chair receives a Complaint and assigns it a Log-in number, along with its receipt date.
2. The Chair then assigns the Complaint to a Committee Member, along with an analysis, commentary and recommendations Worksheet.
3. The Member reviews, analyzes, comments and enters his or her recommendations on the Worksheet, which may take the form of an appropriate option paragraph as outlined below.
4. The Complaint Committee meets on weekly regular basis to review the Members' Worksheets, preparatory to voting as a Committee on the appropriate recommendations to be made to the full Jury panel.
5. The full Jury panel hears the proposed recommendations, and adopts, rejects or requests further action thereon as appropriate. The resolution of cases requiring further action by the Committee is then deferred until the recycling process has been completed and the matter is then re-presented to the full Jury for reconsideration.
6. Following the full Jury's vote, the Foreperson signs off on all approved recommendations.
7. The Committee Chair then requests Staff to send out the standard form letter to the Complainant, acknowledging receipt of the complaint, and including in such letter one of the applicable Option paragraphs as appropriate to the Complainant's case, such as:

   (1) State/Federal issues – no jurisdiction
   (2) No Civil Grand Jury jurisdiction over the subject-matter – no action
   (3) No authority to provide legal advice – no action
   (4) Matter pending in Court or other Judicial venue – no jurisdiction
   (5) Insufficient information provided – suggest more input
   (6) Complaint is illegible – send new Complaint form and request it be either printed or typed, and resubmitted for reconsideration
   (7) The Committee Chair then completes the Log entry to reflect closing.

In reviewing a particular Citizen Complaint, it is essential that the following information be determined from the documentation submitted before the matter can be fully evaluated, namely:

1. Against whom or what governmental agency is the complaint directed?
2. What is the exact nature or substance of the complaint?
3. What action or conduct was improper or illegal?
4. Where and when did the incident complained of occur?
5. What were the consequences of such action?
6. What response, action or remedy is being sought?
7. What relevant documents are attached to the complaint?

HISTORY OF CITIZEN COMPAINTS COMMITTEE ACTIVITY

During its tenure, the 2006-2007 Civil Grand Jury reviewed 73 Citizen Complaints, 18 of which were carried over from the 2005-2006 Civil Grand Jury. The total number indicated, however, does not include the multiple communications received from various individual complainants desiring to either

supplement or otherwise reiterate their original complaint documentation. Such supplemental communications were simply consolidated with the original material up for the Committee's consideration.

The 73 Complaints which were processed fell into 10 basic categories, as reflected by the following breakdown:

COMPLAINT CATEGORIES	NUMBER OF COMPLAINTS
Court Adjudicated Civil Matters	12
Court Adjudicated Criminal Matters	13
Pending Civil & Criminal Matters	2
Abuse by Law Enforcers and/or Jails	23
Requests For Legal Assistance	11
Discrimination Claims	2
Misconduct By Law Enforcement Officers	2
Governmental Malfeasance/Incompetence	1
Unintelligible Allegations	2
Miscellaneous	5
Total:	73 Complaints

DISPOSITION ACTIONS BY CIVIL GRAND JURY

1. No Jurisdiction Over Subject-matter:	34 Complaints
2. No Actions Taken:	34 Complaints
3. Referrals For Further Investigations:	5 Complaints

CONCLUSIONS AND RECOMMENDATIONS

1. From many of the Complaints received, it appears that many of the general public, including those in prison, have some serious misconceptions as to the nature of the role that the Civil Grand Jury can lawfully undertake regarding their Complaints. The best example of an unrealistic request, (probably prompted by fictionalized television crime dramas), is where the Civil Grand Jury is called upon to convene formal hearings, subpoena witnesses, take sworn testimony, and conduct what is tantamount to pre-trial discovery activities, all of which is apparently designed to help make the case for the Complainant in proving his allegations, whatever they might be. The recommendation, therefore, would be to provide sufficiently clear written information to a potential complainant as to just what the Civil Grand Jury can do, and in general what it cannot do.

2. Another common misconception is based upon the belief that the Civil Grand can somehow overturn allegedly wrongful convictions or penalty assessments of one sort or another, discipline State Prison officials and personnel, or to otherwise intervene in pending civil and/or criminal litigation which may not be going particularly well for the complainant.

3. While complainants are constitutionally entitled to petition their government for redress and relief in appropriate cases, the Civil Grand Jury is legally unable to conduct itself in the sometimes bizarre manners requested, nor does it have the resources nor the mandate to do so.

4. To preclude many inappropriate complaint submissions by those who utilize the current Citizen Complaint form, the recommendation is to have imprinted at the top of the face thereof, in bold type, something more definitive than "Please Review Complaint Guidelines"; that such language should plainly spell out that the Civil Grand Jury has no jurisdiction nor authority over issues involving California State entities, Federal agencies, Judges and other judicial officers, nor over past or pending Court cases, either civil or criminal in nature. Such notifications in bold type may not entirely stem the flow of non-jurisdictional matters, but might well serve to reduce inappropriate submissions to the Civil Grand Jury; that further, from a humanitarian standpoint, such information might very well preclude individuals from seeking personally unattainable expectations.

5. In developing the Options utilizations in corresponding with complainants, as outlined above, with particular reference to complaints dealing with out-of-state matters, it is recommended that an additional Option be added to the list, which essentially would read: "The subject-matter of your Complaint appears to involve either individuals or entities who are neither under the control of nor in the service of the County of Los Angeles, and we are therefore unable to take nor recommend any action in your case".

6. Having had the benefit of an enlightening presentation to the entire Civil Grand Jury by the Los Angeles County Department Of Ombudsman, a recommendation is made that the services provided by that entity should be considered by Citizen Complaints Committees in appropriate matters.

7. Predicated upon a citizen's complaint, a Committee investigation was undertaken regarding the manner in which illegal aliens were being processed by law enforcement Departments in the County. The Committee ascertained that on January 25, 2005, the County Board Of Supervisors had approved the entry into a Memorandum Of Understanding with the United States Department Of Homeland Security to perform certain immigration law enforcement functions, on a pilot program basis. It was further determined by the Committee's investigation that since that Program appeared to be successfully functioning at this time, a recommendation is made that said pilot Program as outlined in said Memorandum Of Understanding be authorized to be continued on a permanent basis.

Continuity Committee

Continuity Committee Members

John E. Hackney, Chair

Walter Lappo
Sandra Lee Mohr
Charles Repp Jr.
Bill Wagner

A Report by a Standing Committee of Los Angeles County 2006-2007 Civil Grand Jury

CONTINUITY COMMITTEE REPORT

The Continuity Committee serves as a bridge between all Civil Grand Juries, prior, current and future ones. It is concerned with informing the current Civil Grand Jury of investigation reports done by prior juries, following up on the reports of last year's Civil Grand Jury, and maintaining a continuous record of the successive Juries' reports.

- The Committee reviewed all of the reports published by the five preceding juries. This provided

- An awareness of investigations recently completed to assist the current jury in avoiding unneeded duplications

- An awareness of areas of the County or the Cities that had not been investigated recently

- An appreciation of the style and content of reports

The Committee also initiated two new efforts for Continuity Committees:

- A review of responses from governmental entities after the 90 day period has elapsed. A letter was sent to those who did not respond reminding them of their legal responsibility.

- A separate review of those responses received where specific commitments were made. A letter was sent to each such responder asking for a status of the commitments.

The Continuity Committee developed a manual to assist future Civil Grand Juries. This document includes a spread sheet outlining each investigation from the prior five years, organized by general administrative area, and indicating the main thrust of the investigation and the basic response received.

Another spread sheet lists all investigative reports from the preceding Civil Grand Jury and identifies each in terms of whether a response had been received or not, and whether a commitment to take certain actions was promised.

The Continuity Committee serves to reinforce the role of the Civil Grand Jury, not only in preparing investigations and reports, but in ensuring that those reports are properly responded to, and that commitments made to the Board of Supervisors are met.

Purpose

The Continuity Committee is a Standing Committee, created by each new Civil Grand Jury. Its functions are:

1. reviewing the reports and recommendations made during the prior five years by County Civil Grand Juries—to help the new Jury avoid duplicate Investigations, but also to bring to light topic areas for possible further studies.

2. reviewing County and City responses to the Board of Supervisors and the Supervising Judge in answer to recommendations made by the retiring Civil Grand Jury—to identify any non-responders and also to identify responders whose responses promised efforts that should justify follow-up "status" letters from the Jury.

3. completing for the succeeding Civil Grand Jury an updated Continuity Committee Guide Book.

Edit and Publication Committee

Edit and Publication Committee

Marlene Markheim, Chair

Bob George
Carole Greene
John Hackney
Hannah Margolis
Otha Scott
James Corbett Tasker
Lloyd Thornhill
John Visser
Linda F. Winfield

A Report by a Standing Committee of Los Angeles County 2006-2007 Civil Grand Jury

THE EDIT AND PUBLICATION COMMITTEE

The law mandates that the Civil Grand Jury publish a Final Report prior to the conclusion of its term of office. The Final Report consists of findings, conclusions and recommendations of the various investigations conducted by the Grand Jury.

The Grand Jury is divided into a number of committees, each of which takes responsibility for conducting investigations in their respective field of interest. Prior to commencing any investigations, the committee must have the approval of the entire Grand Jury. In certain instances, the committees are assisted in their investigations by the employment of outside auditing firms.

Once the committees have completed their investigations and have written their reports, they are submitted to the Edit Committee for editing and publication. Prior to publication, all reports must be approved by the entire Grand Jury. The reports are then submitted, respectively to: the Grand Jury Foreperson, County Counsel (the Grand Jury's legal advisor) and the presiding Judge of the Criminal Court. After all parties have signed off, the Edit Committee is responsible for ensuring publication of the Final Report.

1500 copies of the Final Report are distributed. The distribution includes, but is not limited to: the County Board of Supervisors, Superior Court Judges, District Attorney, Public Defender, City Attorney, Probation Department, Sheriff, various County departments, Chiefs of Police in cities throughout the County, Mayors' Offices, City Council, State Legislature, special districts, news media, public libraries, public interest groups and other interested parties. The Final Report is also available on the Internet.

Conditions and Management of Detention Facilities in Los Angeles County

Jails Committee

Charles Repp Jr., Chair
John Visser, Chair

George Buckley
Nola Burnett
Stuart L. Chason
Joe Contreras
Carole J. Greene
John Hackney
Lewis Hastings
Connie Leyba
Hannah Margolis
Marlene Markheim
Sandra Lee Mohr
Otha Scott
James Corbett Tasker
Bill Wagner
Ung Yol Yu

A Report by a Standing Committee of the Los Angeles County 2006-2007 Civil Grand Jury

LOS ANGELES COUNTY DETENTION FACILITIES

EXECUTIVE SUMMARY

The 2006-2007 Civil Grand Jury fulfilled its mandated legal responsibility by inspecting 127 jails, lock-ups, court holding cells, juvenile camps, juvenile detention centers and other penal institutions in Los Angeles County. The general impression is that the staff at these facilities is professional, knowledgeable, and dedicated. The problems are overwhelming, from the large number of inmates to be secured and processed to all of the associated societal problems. While the primary responsibility of the detention facilities continues to be the administration of justice, the myriad unsolved problems of society have been thrust upon these institutions. The jail systems are providing medical treatment, psychiatric care, services for the homeless, etc.

The conclusions of these inspections are outlined in a chart in the Appendix.

Special findings include the following:

Camp Scudder: A juvenile facility which was closed for nine months to convert from a male to a female population. The plumbing was retrofitted. The lack of cleaning and repairing is not only unsightly, but presents a health risk.

Men's Central: The overcrowding is made more complex by the need to separate populations by life style and gang affiliation. The environment is stressful for both staff and inmates. Additionally, there is a rodent and roach infestation; the inmates manufacture weapons out of everything and distil alcoholic beverages out of fruit juices; and the escalator is out of service.

Twin Towers: There are facilities to provide mental health services and medical care. On an average, over 1500 inmates received mental health services in one day. A wide variety of medical services are provided.

Inmates are transferred to Los Angeles County General Hospital when there are not adequate resources within the jail system to treat a medical condition. This year's Civil Grand Jury followed up on the 2005-2006 report "A Disaster Waiting to Happen". Inmates are no longer being placed in wards other than the "Jail Floor". The only inmate-patients in other units were in the ICU as the jail ward doesn't offer that level of care.

Chatsworth Jail: A state of the art detention facility engineered to accommodate 350 prisoners. It is empty and not used.

The recommendations consider problems in staff recruitment and retention, health and safety issues, better use of electronic technology, and academic research to analyse and offer solutions for some of the problems.

HISTORY

The Los Angeles County Penal System is the largest in the United States. Los Angeles County is comprised of 88 cities and an unincorporated area of nearly 2,700 square miles. The daily inmate population in the County exceeds 23,000 men and woman. In addition, over 4,000 juveniles are detained daily in camps, juvenile halls and youth detention facilities.

A recently released study by the Sheriff's Department found that in excess of 25% of county inmates fall under the "deportable criminal alien" category, which includes illegal immigrants and legal immigrants who have committed serious crimes and therefore lost their legal status. By contract with the department of Immigration and Custody Enforcement (ICE). the Sheriff's Department houses these individuals until their cases have been adjudicated, which can be a number of years due to stalling tactics such as repeated appeals.

Processing the criminal immigrants through the justice system, including attorney, court and Sheriff's Department fees, cost taxpayers more than $150 million. Housing the inmates in county jails cost an additional $83 million.

The Sheriff Department transports nearly 1,500,000 prisoners annually to and from detention facilities and the courts. Security during transportation of prisoners is critical to the safety of the citizens of the county and presents a complex set of problems from a logistical standpoint.

The Los Angeles County Civil Grand Jury is mandated by the California Penal Code Sections 919(a) and (b) to inspect county and municipal police department jails, lockups, court holding cells, juvenile camps, juvenile detention centers, and other penal institutions annually. These inspections include but are not limited to, housing conditions, food service with dietary considerations, medical and mental health needs, availability of policy and procedure manuals, telephones, use and condition of safety or sobering cells, availability of rules and disciplinary/penalty manuals, condition of restrooms and showers and availability of personal care items. The number of staff and adequacy of their training background is an additional important issue for each of the facilities visited.

Other agencies conduct in-depth inspections of these facilities on an annual or semi-annual basis. These agencies include local and state health departments, local fire departments, the California Board of Corrections and Rehabilitation, and the California Department of Justice. These agencies report their findings directly to the authorities in charge of the facility.

PURPOSE

The purpose of the 2006-2007 Civil Grand Jury was to carry out the mandate to inspect as set forth in California Penal Code Section 419. The Jury's goal was to inspect each adult and juvenile detention facility operated in Los Angeles County by local agencies, make findings and recommend changes for improvement, if indicated, and recognize excellence. In addition, special attention was afforded to the medical and mental health services provided to the inmate population at Men's Central and Twin

Towers. We also evaluated the Twin Towers Reception (Intake) Center. Detailed findings are included below under "**Findings".** Furthermore, we are commenting on several of the Juvenile camps which we feel merit further discussion than can be accomplished, because of space constraints, in the Jail Notations columns in the full jail list in the Appendix.

INVESTIGATIONS

METHODOLOGY

A list of detention facilities was compiled from various sources, revised and updated where necessary. The Civil Grand Jury selected 16 jurors to investigate the Detention Facilities in Los Angeles County. The list of Detention Facilities was sorted by zip code and assigned to those jurors who resided in the area near the facilities to be inspected. This system minimized the distances traveled to and from the facilities to be inspected by each Juror. A total of 127 detention facilities were inspected. A list of these facilities is included in appendix to this report with comments as indicated. Several facilities, however, warranted a more detailed commentary and are included under **"Findings"**

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FINDINGS

Camp Scudder: Female Juvenile Facility

Camp Scudder was closed for a period of nine months so that it could be refurbished and the plumbing converted for use by an all female population. We visited this facility 3 weeks after reopening and were dismayed by what we found.

The plumbing in the dormitory had indeed been converted but the classrooms were dirty, dark and crowded with stacks of material and equipment. It was impossible to see through the windows because they were caked with thick layers of dirt. The walls were cracked and peeling and in desperate need of paint. The public restrooms were dirty. Thick bird droppings on the walkways were not only unsightly but posed a real health risk. Many of the exterior beams exhibited severe dry rot.

The one exception to this gloomy picture was the kitchen and dining room. The manager obviously takes great pride in keeping her area immaculate, organized and well stocked.

We revisited this Camp in April and noted some of the problems reported to Probation had been resolved but many had not yet been addressed. The staff from both Probation and LACOE is professional, helpful and sincere in their desire to help solve the remaining problems.

Men's Central Jail

The men's Central Jail is a Type III (High Security) 6,000 inmate facility. It is the largest jail in the free world. This facility was constructed in 1963. Overcrowding is a continuous problem that is made even more complex due to the need to separate members of the various life style and gang affiliations. At the time of this inspection the jail had 34 different inmate classifications. These classifications include gangs, ethnic groups, alternative life styles and those with serious mental issues. The courts have mandated the reduction of inmates per cell block to reduce tension and provide improved inmate management. We did not see evidence of any violence during our inspection tour. However the jail had just completed a lockdown prior to our inspection tour.

Turn over of staff at this facility is of concern. The reasons for the turnover are the same at each of the detention facilities. For details please refer to the Staff turnover portion of this report.

During our inspection this past September we were made aware of rodents and roaches in the cell block areas. These cell blocks are cleaned daily however the inmates eat in their cells and not all food is consumed at meal time. The remaining food is used for barter or frequently the fruit is distilled to create an alcoholic drink.

During our inspection we were required to use an escalator that was out of service. This elevator is in use daily as a stairway to go from floor to floor. We were informed that the repair was very expensive and had been needed for months. This is a health and safety issue of concern for the inmates, the staff and visitors,

Inmate Reception Center (IRC)

The Inmate Reception Center is the primary point of intake and release for all male inmates within the Los Angeles County Sheriff's detention system. The IRC Operations Division reports that they processed 177,546 inmates in 2006. There are no dormitories; but it has showers and toilets, and cold food is served. The Center has an overflow section which is physically a regular jail pod where mental health and health care professionals observe and prescribe specific treatment necessary for an individual.

Each newly arriving inmate is evaluated and classified for mental health, physical problems, alternative life style, gang affiliation and potential for violence. Inmates are routinely questioned concerning citizenship at the time of entry and prior to release. All of this information is used to classify where the inmate will be housed within the detention system.

The IRC is responsible for the storage and maintenance of all inmate clothing, personal property and funds while the person is incarcerated. Funds for use by the inmates may be deposited at this facility. This area has 800 employees of which 450 are professional staff.

Some inmates are released to Immigration and Customs Enforcement (ICE) or to the state prison system.

When a person who completed his obligations to the justice system is released and is homeless, there are services available to provide shelter. The Department of Health has an office to provide referral for follow-up health care services.

Los Angeles County/University of Southern California Hospital

This Grand Jury followed up on the report "A Disaster Waiting to Happen" of the 2005-2006 Civil Grand Jury. Their findings were: Inmate-patients were placed on other wards than the Thirteenth Floor Jail Ward. The reasons for this placement were never fully explained. There was bed space available on the Jail Ward. The inmate -patients were scattered on other floors and were restrained to their beds by handcuffs. This practice presented a clear and present danger to the other, non-inmate/criminal patients, whom often were unaware of the criminal status of these men.

When the 2005-2006 Civil Grand Jury Report concerning this problem came to the attention of the Mayor of Los Angeles, Los Angeles County Board of Supervisors, the Sheriff's Department and others, this problem was almost immediately corrected.

During this year's inspection, there were no inmate-patients on any of the open wards. The only inmate-patients not on the Jail Ward were in Intensive Care Units. The Jail Ward does not have an ICU. A total of five inmate- patients were in the ICU. Three men in the ICU were secured to their beds with leg irons and monitored every hour by Sheriff Department Personnel; a log was kept as to their status with regard to security. Two pregnant inmate-patients were hospitalized in the women's facility; they were checked hourly by Sheriff's personnel and records were kept.

Twin Towers' Mental Health and Medical Issues

a. Mental Health Services at Twin Towers

Department of Mental Health personnel provide direct services within this jail. Inmates are screened for serious mental health problems in the Twin Towers Correctional Facility Inmate Reception Center. All inmates are asked 15 questions verbally. If one or more answers are positive, they are referred to mental health clinicians for further evaluation. Additionally inmates are referred for mental health screening by the Sheriff's Department based on their behavior, past records, or information from the Courts or community. Over 40,000 mental health evaluations were performed in the reception center in the calendar year 2006. An overflow area with dormitory facilities has been created outside of the reception area to allow

time for the clinical evaluations. The volume of inmates needing evaluations fluctuates greatly with the possibility of several hundred in one day.

The current statistical tracking system does not give information regarding diagnosis or level of functioning. Inmates are housed based on individual needs in dormitory, high observation or inpatient settings. On an average there are 45 inmates in the inpatient setting and up to 280 in the High Observation areas. If self injury is a concern, inmates are given safety gowns for clothing. In the High Observation areas Sheriff's Deputies physically walk among the inmates for two random checks each half hour. On an average over 800 inmates are receiving psychotropic medication. In addition to medication management, treatment for co-occurring substance abuse, group treatment, individual counselling, and release planning are provided based on the individual inmates' needs. Over 1500 inmates on an average receive mental health services in one day. There are 40 funded vacancies for mental health personnel in the jail.

b. Medical Issues at Twin Towers

Transfers of Inmates to LAC/USC Hospital.

The Medical Services Department (hospital) is housed in Twin Towers. The jail facilities have Electronic Medical Records with a medical log. There is a Quality Assurance Program and a Case Manager Program for follow-up. Jail personnel are being trained to deal with minor medical/surgical issues. Urgent care systems are being formulated.

Inmates are transferred from jail to LAC/USC for emergency, inpatient, and outpatient care. Medical information often is not available when the inmate is transferred. Transportation of the inmate is a burden and could be a danger to sheriff's staff. The medical staff at the jail lacks specialists which results in inmate transfers. The recommendation is to use 12 telemedicine units to enable diagnostic work up without a transfer from the jail. Digital radiology enables transmission of imaging data for interpretation. Plans are in place to add MRI and CT scans to the system. When this pilot project is in place, it will be assessed by the Department of Justice and the State of California.

Medical Staff Education and Training

There is active recruitment of nurses with a competitive benefits package and opportunity for advancement and education. Federal grants are available as the jails are located in under served communities. The lack of staff is an ongoing problem. The high risk environment makes it difficult to fill staff positions. Also, there is lack of space and lack of clinical care sites.

During this year's inspection, there were no inmate-patients on any of the open wards. The only inmate-patients not on the Jail Ward were in Intensive Care Units. The Jail Ward does not have an ICU. A total of five inmate- patients were in the ICU. Three men in the ICU were secured to their beds with leg irons and monitored every hour by Sheriff Department Personnel; a log was kept as to their status with regard to security. Two pregnant inmate-patients were hospitalized in the women's facility; they were checked hourly by Sheriff's personnel and records were kept.

Chatsworth Facility

A shining example of a state of the art detention facility is exemplified by the Chatsworth Jail, which is under the control of the Sheriff's Department. It was engineered to accommodate 350 prisoners and is housed in the basement of the Superior Court building in Chatsworth.

Every modern technological advance was utilized and no expense was spared to ensure the security and well-being of each prisoner.

The only fault this Civil Grand Jury found is that the Chatsworth Jail sits in an empty, pristine and unused condition, despite the fact that the Board of Supervisors is well aware of the appalling conditions at both Twin Towers and Men's Central Jail.

Who is responsible for the multimillion dollar boondoggle, also known as the Chatsworth Jail?

CONCLUSION

After this inspection one can appreciate the vastness and complexity of the problems within the detention facilities in Los Angeles County. The majority of facilities were in satisfactory condition, and for the most part, it is an exceptional jail system (Please refer to the Appendix for specific details about each facility). The staff was helpful and courteous with professionalism, knowledge, and dedication. One underlying problem in many areas is that of recruitment and retention of staff. There are vacant funded positions. The challenge is in maintaining staff under difficult circumstances.

Unsolved societal problems are being tackled. All people detained are suspected or convicted of breaking some law. But some people present symptoms of mental or physical diseases, treatment is prescribed within the jail system. Follow up is offered after incarceration. The homeless are referred to an agency which may assist them.

The inmates in the Los Angeles Jail System receive better medical services than many of the citizens of Los Angeles County who are paying for these services. Medical services are provided on an almost instant basis. There is no waiting for an appointment to see a medical professional. Some inmates take advantage of these services in an attempt to avoid their daily routines with which they are discontented.

RECOMMENDATIONS

Recommendations are for the Sheriff's Department, Department of Health, Department of Mental Health, Probation Department and the Board of Supervisors

1. Men's Central Jail: Increase treatment of cell areas to remove infestation of vermin.

2. Men's Central Jail: Repair the escalator or remove and replace with a safe walkway that meets commercial building codes and ADA requirements.

3. Camp Scudder: The place needs to be cleaned, repaired, and painted.

4. Mental Health: Develop a formal academic training program for the speciality of providing mental health services in a jail environment. (The Department of Mental Health has already applied for a couple of research grants to study specific populations - women prisoners, 18-24 year old inmates). Currently the academic training of mental health professionals does not really have curricula for this speciality.

5. Electronic Records: Medical electronic records available within the jail should be accessible when the inmate transfers to another facility.

6. Medical Care: Complete and activate the telemedicine system in order to decrease the number of inmates transferred out of the jail system.

7. Medical Care: A system to need to document medical indications for transfer to LAC/USC for emergency, inpatient and outpatient care. Analysis of this data should facilitate a decrease of inmates transferred.

APPENDIX

The following is a list, in alphabetical order, of the facilities inspected by
the 2006-2007 Los Angeles County Civil Grand Jury
with comments on each facility.

JAIL	ZIP CODE	ADDRESS	PHONE	JAIL NOTATIONS
77th St Regional Division	90003	7600 S. Broadway, Los Angeles	213.473.4851	1st floor holding cells have lots of graffiti, 2nd and 3rd floors are in good shape. 1st Fl. LAPD/2nd & 3rd
Alhambra City Jail	91706	211 So. First St., Alhambra	626.570.5145	Clean facility well managed and operated by private jailers, satisfactory.
Alhambra Superior Court Holding Facility	91711	150 W. Common-wealth, Alhambra	626.308.5537	Holding facility, day use only for inmates brought in for trial, in the opinion of the jury, this facility meets all requirements, satisfactory.
Arcadia City Jail	91723	250 W. Huntington Dr., Arcadia	626.574.5150	Immaculate new facility, superior in all respects, operated by Arcadia Police Dept. with five (5) jailers, day use only, "pay to stay" inmates used for maintenance, exceptional facility.
Arraignment Court	90012	429 Bauchet St., Los Angeles	213.485.2671	No jail facilities at this location.
Avalon LASD	90704	215 Sumner, Catalina Island	213.972.7828	Satisfactory. One jailer. A deputy must act as the second jailer. Transport prisoners via public transportation to County jails.
Azusa Jail, City of	91766	725 N. Alameda Ave., Azusa	626.812.3277	Clean, well managed jail, in the opinion of the jury, this facility meets all requirements, satisfactory.
Baldwin Park, City of, Jail	91773	14403 Pacific Blvd., Baldwin Park	626.960.1955	Clean, well managed jail, in the opinion of the jury, this facility meets all requirements, thermometer needed in refrigerator, satisfactory.
Bell Jail	90201	6326 Pine Ave., Bell	323.585.1245	Satisfactory. Bell PD and Wackenhut Correction Officers. Facility used as a work ordered release program. Inmates pay $75 a day to reside there.
Bellflower Court	90706	10025 Flower St., Bellflower	562.804.8005	Satisfactory. Well operated by LACSD.
Beverly Hills	90210	464 Rexford, Beverly Hills	310.550.4951	Satisfactory. Up to five phone calls to insure care for children and pets.
Burbank City Jail	91741	200 N. Third St., Burbank	818.238.3010	Facility is superior in all respects, staffed by private jailers, personnel professional and helpful, exceptional.

Burbank Superior Court Holding Facility	91744	300 E. Olive Ave., Burbank	818.557.3493	Holding facility for inmates brought in for trial, day use only, clean and well managed, by L.A. County Sheriffs' Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
Camp Afflerbaugh	91706	6631 Stephens Ranch Road, La Verne	909.593.4937	Senior juvenile camp for low risk juveniles 14-16 years, old facility, clean and well managed, but needs renovating Nurse on staff. Juveniles required to attend 30 hours of school per week, needs modern telephone system ASAP, excellent Director, needs better school program.
Camp Gonzales	91302	1301 N. Las Virgenes Rd., Calabasas	818.222.1192	Juvenile probation camp. Extensive academic and traditional programs. Males only. Active community support. Outstanding facility and programs.
Camp Kilpatrick	90265	427 S. Encinal Canyon Road, Malibu	818889.0260	Juvenile Camp for education purposes, the Camp would like sentences based on school cycles. Excellent sports program. Sports facilities need improvements.
Camp Mendenhall	93532	4230 Lake Hughes Rd., Lake Hughes	661.724.1213	Juvenile probation camp. Old facility operated in a military style. Excellent discipline.
Camp Miller	90265	427 S. Encinal Canyon Road, Malibu	818.889.0260	Juvenile Camp needs more drug treatment. Excellent education opportunities.
Camp Munz	93532	4220 Lake Hughes Rd., Lake Hughes	616.724.1211	Juvenile probation camp. Mirror image of Camp Mendenhall.
Camp Paige	91750	6601 Stephens Ranch Road, La Verne	909.593.4937	Lower risk camp for juveniles serving 6-12 month sentences, clean and well managed, in the opinion of the jury, this facility meets all requirements, buildings need renovating, modern telephone system badly needed.

Camp Rocky	91016	1900 N. Sycamore Canyon Road, San Dimas	909.599.2391	Juvenile camp for problem/difficult boys, some with psychological problems, is well maintained, new Director has cleaned up disciplinary problems, school on premises, all students attend school ½ day, nurse on staff, all meals prepared in camp kitchen, in the opinion of the jury, this facility meets all requirements but needs to be upgraded and modernized.
Camp Scott	91350	28700 N. Bouquet Cyn. Rd., Saugus	661.296.8500	Juvenile probation camp. Females only. Lacks opportunity for academic and vocational training. Good mental health program.
Camp Scudder	91350	28700 N. Bouquet Can. Rd., Saugus	662.296.8811	Became an all female detention facility in January of 2007. Se special notation in Jail Report.
Carson Jail	90745	21356 S Avalon Blvd., Carson	310.830.1123	Superior. Everything in excellent condition. Trustees keep the building clean and painted at all times.
Central Area Jail	90014	251 E. 6th St., Los Angeles	213.485.3294	Facility appears well kept.
Century Regional Detention	90262	11701 Alameda St., Lynwood	310.537.6111	Outstanding Mental Health Facility for women operated by LACSD. Reopened in June 2005 as a women facility. Kept clean by inmates. Large kitchen feeds 2300 inmates and sends food to Carson, Lakewood & other facilities.
Challenger-Camp Jarvis	93536	5300 W. Ave. L, Lancaster	661.940.4111	Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles.
Challenger-Camp McNair	93536	5300 W. Ave. L, Lancaster	661.940.4146	Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles.

Challenger-Camp Onizuka	93536	5300 W. Ave. L, Lancaster	661.940.4144	Currently a female facility until Camp Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles. Scudder remodeling is complete.
Challenger-Camp Resnick	93536	5300 W. Ave. L, Lancaster	661.940.4044	Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles.
Challenger-Camp Scobee	93536	5300 W. Ave. L, Lancaster	661.940.4011	Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles.
Challenger-Camp Smith	93536	5300 W. Ave. L, Lancaster	661.940.4011	Juvenile probation camp. They address all the mental health issues and all 24/7 medical needs for the entire Juvenile Camp System. The six Challenger Camps combined can accommodate up to 650 juveniles.
Chatsworth	91311	9425 Penfield Ave., Chatsworth	818.576.8800	This is a state of the art facility which can accommodate up to 350 prisoners. Is presently not used to house any prisoners.
Claremont, City of, Jail	91776	570 W. Bonita Ave., Claremont	909.399.5411	Small, well managed, clean jail, very nice, needs better lighting in cells, in the opinion of the jury, this facility meets all requirements, satisfactory.
Covina, City of, Jail	91790	444 No. Citrus Ave., Covina	626.858.4413	Immaculate facility due to weekly inspection by Police Chief, in the opinion of the jury, this facility meets all requirements, very satisfactory.
Crescenta Valley Jail	91101	4554 Briggs Ave., La Crescenta	818.248.3464	Older facility, clean, operated and well managed by Los Angeles County Sheriff's Dept., should be replaced or renovated, satisfactory.
Culver City	90230	4040 Duquesne, Culver City	213.974.4916	Satisfactory. Facility, although 20 years old, was in excellent condition.

Devonshire Area Jail	91325	10250 Etiwanda Ave., Northridge	818.756.8266	Older facility built in 1970. They are the intake for LAUSD, CSUN, General Services and CHP arrestees.
Downey Courts	90242	7500 Imperial Blvd., Downey	562.803.7052	Unsatisfactory. Older LACSD facility, needs graffiti removal, painting. Refrigeration thermometer inoperative for several weeks.
Downey Jail	90241	10911 Brookshire Ave., Downey	562.861.0771	Satisfactory. Operated by Downey PD. Last years problems have been corrected.
East Los Angeles Sheriff Station	90022	5019 E. 3rd St., Los Angeles	323.264.4151	Clean, well managed, busy jail, in the opinion of the jury, this facility meets all requirements, satisfactory.
East Los Angeles Superior Court Holding Facility	90022	214 So. Fetterly, Los Angeles	213.780.2225	Holding facility, day use only for inmates awaiting trial, in the opinion of the jury, this facility meets all requirements, satisfactory.
Eastlake Juvenile Hall	90033	1605 Eastlake Ave., Los Angeles	323.226.8611	Large juvenile Type III facility, with major educational components, was toured by Civil Grand Jury. Inspection findings noted, with respect to special need population.
Edelman Children's Court	91766	201 Centre Plaza Dr., Monterey Park	323.526.6030	Holding facility for adult inmates brought in to attend their children's court hearing, operated and managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
El Monte City Jail	91731	11333 E. Valley Blvd., El Monte	626.575.4121	Older facility in good condition, new facility in process to replace it, in the opinion of the jury, this facility meets all requirements, satisfactory.
El Segundo	90245	348 Main Street, El Segundo	310.524.2200	Satisfactory. 2nd metal detector between booking and cells. Luminous fire belt attached to wall for use in emergency evacuations.
Foothill Area Jail	91331	12760 Osborne, Pacoima	818.756.8865	Does not book females. They have Crime Analysis capabilities here.
Gardena	90247	1700 W. 162nd Street, Gardena	310.217.9500	Satisfactory, very clean.
Glendale City Jail	91105	131 No. Isabel St. Glendale, CA	818.548.3139 /548.3124	Brand new facility, superior in all respects.

Glendale Superior Court Holding Facility	91024	600 E. Broadway, Glendale	818.500.3493	Holding facility for inmates brought in for trial, day use only, clean, well managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
Glendora, City of, Jail	91214	150 So. Glendora Ave, Glendora	626.914.8250	Older facility in immaculate condition, in the opinion of the jury, this facility meets all requirements, has Support Services Supervisor to oversee maintenance, very satisfactory.
H.R. Moore & Kenyon Juvenile Justice Center	90001	7672 S Central Ave., Los Angeles	323.583.2774	Satisfactory. These are 2 schools for juveniles assigned by the courts and handled by the probation dept. They are doing a very good job with the facilities they have to work with.
Hawthorne	90256	12501 Hawthorne, Hawthorne	323.226.8611	Satisfactory. New facility (3 years).
Hermosa Beach	90254	251 East 6th Street, Hermosa Beach	310.318.0360	Satisfactory
Hollenbeck Jail	90033	2111 E. 1st St., Los Angeles	323.266.5964	Temporary holding only. Replacement facility under construction nearby.
Hollywood	90028	1358 Wilcox, Hollywood	213.485.5125	Satisfactory. Old. Floor needs painting. No females. Medical issues to Parker Center.
Huntington Park Jail	90255	6542 Miles Ave. Huntington Park	323.862.6622	Superior Facility operated by Huntington Park PD. Inmates pay to serve court-ordered Weekends.
Industry, City of, Jail	90022	150 N. Hudson Ave. City of Industry	626.330.3322	Facility in the opinion of the jury, this facility meets all requirements, in need of major renovation, adequate lighting needed in cells. Managed by L.A. County Sheriff' Department. Satisfactory
Inglewood	90301	1 Manchester Blvd., Inglewood	310.412.5325	Satisfactory. Holding cells had graffiti, cracked paint, no air conditioning, but clean.
Irwindale, City of, Jail	90022	5050 N. Irwindale Ave. Irwindale	626.962.3601	Holding type facility, all detainees are immediately transported to City of Glendora Jail for booking and processing, in the opinion of the jury, this facility meets all requirements, satisfactory.

Jail Ward LAC General Hospital	90033	1200 N State St., Los Angeles	323.226.4563	Satisfactory. Operated by LACSD. They had 4 inmates in ICU none were with regular patients. They had 2 women inmates in the Women Hospital. They have corrected all the problems that were noted in the CGJ report of 2005/6. They will move into the new building latter part of 2007.
L.A. Juvenile Justice Center	90001	7625 S. Central Ave., Los Angeles	323.586.6116	Satisfactory. Ran by LACSD & Probation Dept. Holding cells for juveniles awaiting Disposition. LACSD maintains 2 one person cells for adults pick up on juvenile warrants.
La Verne, City of, Jail	91754	2061 Third Ave., La Verne	909.596.1913	Older facility, clean, needs renovation, in the opinion of the jury, this facility meets all requirements, satisfactory.
Lakewood Jail	90712	5130 N. Clark Ave., Lakewood	562.866.9061	Satisfactory. Operated by LACSD. They had 700 bookings for their own station plus other stations in the area even some CHIPs plus 70 juveniles, all of these for a one month period.
Lancaster	93534	501 West Lancaster Blvd., Lancaster	661.948.8466	Graffiti program not enforced. At one time they were the busiest facility in the county. In September 2006 when the Palmdale facility became operational the population here was substantially reduced.
Lennox LASD	90304	4331 Lennox Blvd., Lennox	310.671.7531	Satisfactory. Trustee dormitory
Lomita Police LASD	90717	21623 Narbonne Ave., Lomita	310.539.1661	Satisfactory. Using trustees from IRC
Long Beach South Division	90802	400 W. Broadway, Long Beach	562.570.7260	Satisfactory. Very large jail (Long Beach population - 500,000. 18,000 bookings in 2006. Total capacity is 400, 200 women and 200 men. An MD visits twice each day. Nursing care is available 24/7.
Los Angeles World Airports	90045	6320 W. 96th Street, Los Angeles	310.645.8818	Satisfactory. Small holding area. Coordinates with TSA, FBI, Customs, Immigration, US Marshal, and LAPD.
Manhattan Beach	90266	420 15th Street, Manhattan Beach	310.802.5100	Newly constructed police station. State of the art jail.
Marina del Rey LASD	90292	13851 Fiji Way, Marina del Rey	310.823.7762	Satisfactory. Also patrols Marina area in watercraft.

Maywood Jail	90270	4317 Slauson Ave., Maywood	323.562.5008	Satisfactory. Operated by LACSD. When inmates are there they get three hot meals A day.
Men's Central Jail	90012	441 Bauchet St., Los Angeles	213.974.4916	Civil Grand Jury tour of this largest jail in the Free World completed in August. Inspection findings with respect to vermin, graffiti, inadequate cleaning, other.
Mental Health Court	90065	1150 San Fernando Rd., Los Angeles	323.226.2908	Temporary holding only. Inspection reports exemplary management.
Mira Loma Detention Center	93536	45100 60th St. West, Lancaster	661.949.3811	This is an ICE facility. Only undocumented immigrant detainees are housed here, segregated by ethnicity. They provide the detainees with ethnic meals.
Mission Hills	91345	11121 N. Sepulveda Blvd., Mission Hills	818.838.9800	Operated by LAPD, Well run. This is a new facility.
Monrovia, City of, Jail	91731	140 E. Lime, Monrovia	626.250.8000	Older, clean, well managed facility, in the opinion of the jury, this facility meets all requirements, satisfactory.
Montebello City Jail	91108	1600 Beverly Blvd., Montebello, CA	323.887.1313	Clean facility operated by Correctional Systems, Inc., satisfactory.
Monterey Park City Jail	91780	320 W. Newmark, Monterey Park	626.307.1254	Clean facility operated by Correctional Systems, Inc., satisfactory.
Newton	90011	3400 S Central Ave., Los Angeles	562.863.8711	Satisfactory. Operated by LAPD. NO overnight guest, Men sent to Parker, women sent to 77th St.
North Hollywood	91601	11640 Burbank Blvd., N. Hollywood	818.623.4016	Operated by LAPD. They offer a new kindergarten through 5th grade Pre-Delinquency Program.
Northeast Jail	90065	3353 San Fernando Rd., Los Angeles	213.485.2566	Temporary holding only. Inspection reports exemplary management.
Norwalk Court	90650	12720 Norwalk Blvd., Norwalk	562.807.7283	Satisfactory. Operated by LACSD. Well run with some graffiti to be cleaned up soon. This is an old building in need of repairs

Norwalk Jail	90650	12355 Civic Center Dr., Norwalk	562.863.8711	Satisfactory. Operated by LACSD. IN good shape for an old facility. Normal pranks by inmates, using T.P. to wet and throw against ceiling light to stick and make them darker in the cells & some graffiti.
Pacific Division LAPD	90066	12312 Culver, Los Angeles	310.837.1221	Satisfactory. Jail management is through the jails division not the patrol division. 77th Street is the supervisory authority. No female or juvenile prisoners.
Palmdale	93550	1020 East Ave. Q, Palmdale	661.267.4300	New facility, well run. They have a Booster Club program here.
Parker Center (The Glass House)	90012	150 N. Los Angeles St., Los Angeles	213.485.2510	New Metro Jail being built to replace this older facility.
Pasadena City Jail	91789	207 N. Garfield, Pasadena	626.744.4501	Clean, freshly painted and well managed facility, superior in all respects.
Pasadena Superior Court Holding Facility	91101	300 E. Walnut, Pasadena	626.356.5555	Holding facility, clean and well managed by Los Angeles County Sheriff's Dept., day use only.
Pico Rivera	90660	6631 Passons Blvd., Pico Rivera	562.949.2421	Satisfactory. Operated by LACSD. Trustees keep the cells clean and prepared for other work. Corrections have been made.
Pitchess-East Facility	91384	29320 The Old Road, Castaic	661.295.8812	Well run. Gang members are segregated.
Pitchess-NCCF Facility	91384	21340 The Old Road, Saugus	661.295.8812	This is the "Flagship" of custody. Excellent in every way; library, computer classes, print shop, sign shop and sewing shop which fabricates most jail uniforms for the County. The kitchen shop prepares and cook-chills 24,000 meals per day for all Sheriff's facilities in the County which have no kitchens. Can accommodate up to 4000 inmates.
Pitchess-North Facility	91384	29320 The Old Road, Castaic	661.295.8812	Well run. Dorms are similar to Twin Towers.
Pitchess-South Facility	91384	29320 The Old Road, Castaic	661.295.8812	Well run. Gang members are segregated.

Pomona North Superior Court Holding Facility	91766	350 W. Mission Blvd., Pomona	909.630.3230	Holding facility for inmates brought in for trial on misdemeanor charges, day use only, well managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
Pomona South Superior Court Holding Facility	91766	400 Civic Center Plaza, Pomona	909.620.3326	Large holding facility for inmates brought in for trial on felony charges, day use only, well managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
Pomona, City of, Jail	91210	490 W. Mission Blvd., Pomona	909.620.2131	Large busy jail, cells need better lighting, refrigerator needs thermometer, satisfactory.
Rampart Jail	90026	2710 W. Temple St., Los Angeles	213.485.4061	Replacement facility under construction nearby.
Redondo Beach	90277	401 Diamond, Redondo Beach	310.318.0616	Satisfactory. Offers "pay to stay"
Rio Hondo Superior Court (El Monte) Holding Facility	91731	11234 E. Valley Blvd., El Monte	626.580.2110	Very busy holding facility, day use only, well managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, satisfactory.
San Dimas, City of, Jail	91210	270 So. Walnut St., San Dimas	909.599.1261	Brand new facility which includes a jail, computer lab and a disaster command center with large room that can be partitioned to create two (2) separate command centers in case of a disaster, well managed by Los Angeles County Sheriff's Dept., should be model for all future jails, new fire station is part of complex, command center area and computer lab are available to the community when not in use. In the opinion of the jury, this facility meets all requirements, exceptional.
San Fernando	91340	910 First St., San Fernando	818.898.1267	San Fernando has its own Police Department. Clean, well run facility.
San Gabriel, City of, Police Dept. Jail	90640	625 So. Del Mar Ave., San Gabriel	626.308.2828	Holding facility only, detainees are then transported to other city jails, in the opinion of the jury, this facility meets all requirements, satisfactory.

San Marino Police Dept. Jail	91105	2200 Huntington Dr., San Marino	626.300.0720	Small, largely unused jail, detainees immediately transported to Alhambra jail for processing, in the opinion of the jury, this facility meets all requirements, satisfactory.
Santa Clarita (2 Facilities)	91355	23740 Magic Mountain Pkwy., Valencia	661.255.1121	They house both male and female inmates. Well operated.
Santa Monica	90402	1685 Main, Santa Monica	310.458.8482	Excellent New jail
Sierra Madre Holding Facility	91024	242 Sierra Madre Blvd., Sierra Madre	626.355.1414	Six (6) hour holding facility, small and clean, in the opinion of the jury, this facility meets all requirements, satisfactory.
Signal Hill	90806	1800 Hill Street, Signal Hill	562.989.7200	Satisfactory
South Gate	90280	8620 California St., South Gate	323.563.5400	Unsatisfactory, Operated by SGPD. Unsafe drunk tank. Everything covered with dust. Lots of graffiti. City only allows one custodial person to keep the cells and offices up, not enough.
South Pasadena Police Dept. Jail	91108	1422 Mission St., South Pasadena	626.799.1121	Small, largely unused jail, detainees are immediately transported to Pasadena jail for processing, in the opinion of the jury, this facility meets all requirements, satisfactory.
Southeast Jail	90061	145 W. 108th St., Los Angeles	213.972.7828	No longer a jail; 77th Street facility now serves area.
Southwest Jail	90062	1545 MLK Blvd., Los Angeles	213.485.2615	Temporary holding facility only. Fresh paint throughout. Graffiti very limited.
Sylmar Juv. Hall (2 Facilities)	91342	16350 Filbert St., Sylmar	818.364.2022	This is a detention center and resident hall. The court in this facility hears outstanding juvenile warrant violations. High end offenders are housed here.
Temple City Jail	91780	8838 Las Tunas Dr., Temple City	626.285.7171	Older facility operated and well managed by Los Angeles County Sheriff's Dept., in the opinion of the jury, this facility meets all requirements, should be replaced by modern facility, satisfactory.
Torrance	90505	5019 E. 3rd St., Torrance	323.264.4151	Satisfactory. Excellent communications system.

Twin Towers	90012	441 Bauchet St., Los Angeles	213.473.6080	Medical inspection and related report completed September 28, 2006. Physical plant and management inspection to be completed February 1st, 2007.
Van Nuys Jail	91401	6240 Sylmar Ave., Van Nuys	818.756.8358	This jail is old and dark. In need of rebuilding. LAPD transports all San Fernando Valley arrestees to this facility.
Vernon	90058	4305 Santa Fe Ave., Vernon	323.587.5171	Superior. Operated by VPD. Everything is A-1, they tape everything. All departments look good.
Walnut Sheriff's Station	91789	21695 E. Valley Blvd., Walnut	818.913.1715	Large Sheriff's station, clean and well managed, in the opinion of the jury, this facility meets all requirements, satisfactory.
West Covina Superior Court Holding Facility	91790	1427 West Covina Parkway, West Covina	818.814.8585	Holding facility for inmates brought in for trial, day use only, clean, well managed, in the opinion of the jury, this facility meets all requirements, satisfactory.
West Covina, City of, Jail	91754	1440 W. Garvey Ave., West Covina	626.939.8550	Nice clean facility, in the opinion of the jury, this facility meets all requirements, some damage on floors and walls, in need of renovation, satisfactory.
West Hollywood LASD	90069	780 San Vicente, West Hollywood	310.855.8550	Satisfactory. Hand held cameras required for interview rooms. Have transgender cells.
West LA Juvenile Court	90025	1633 Purdue, Los Angeles	310.312.6500	Purdue location is satisfactory. Robertson Boulevard location is CLOSED.
West Valley	91335	19020 Vanowen St., Reseda	818.756.8545	New facility. Well staffed, well operated.
Whittier	90602	7315 S Painter Ave., Whittier	562.945.8250	Satisfactory. Operated by LACSD 7 Correction Officers. In good shape for an old building.
Wilshire Area Jail	90019	4861 W. Venice Blvd., Los Angeles	213.473.0476	Temporary holding facility only. Some peeling wall paint; limited graffiti.

Speakers and Events Committee

Speakers and Events Conmmittee

Sandra Lee Mohr, Chair

A Report by a Standing Committee of Los Angeles County 2006-2007 Civil Grand Jury

SPEAKERS AND EVENTS

The function of this committee is two-fold: to invite speakers to address the Jury and to arrange attendance at functions, events or offsite locations. Approval of 14 jurors is required in order to invite speakers to address the entire panel. City and county officials are invited annually. This committee is also responsible for handling special requirements
and requests of invited speakers, such as a microphone, power point projector or flip charts. These items must be requested in advance from the office staff. Guest speakers requested by individual investigative committees are invited by that specific committee and usually address only the members of that committee.

The Civil Grand Jury is often requested to visit facilities, investigate offsite locations and attend various functions. If these functions are for the entire Jury, we use the services of the Los Angeles Sheriff's bus for transportation. The request is prepared by the Speakers and Events chair and processed by the office staff. It is furthermore this committee's responsibility to arrange for any tours or gatherings requested and approved by the requisite 14 votes.

Guest Speakers

- Tyler Mc Cauley – Los Angeles County Auitor/Controller
- Paul Obney – Managing Partner Obney and Associates
- Judge David Wesley – Supervising Judge, Superior Court of California
- Gordon Trask – County Counsel's Office
- John Van de Kamp – Former California Attorney General
- Richard Riordan - Former Los Angles Mayor
- Sheriff Lee Baca – Sheriff of Los Angeles County
- Rocky Delgadillo – Los Angeles City Attorney
- Paul Costa – DWP Solar Program
- Laura Chick – City of Los Angeles Controller
- William Bratton – Chief of Los Angeles Police Department
- Connie Rice – Co-Director of the Advancement Project, Civil Rights Attorney
- Dr. Bruce Chernof, MD – Director and Chief Medical Officer, Health Services
- John R. Cochran – Chief Deputy Director, Health Services
- Vivian Branchick – Chief Nursing Officer, Health Services
- Carol Meyer – EMS Director, Health Services
- Cheri Todoroff – Oversight Deputy, Health Services
- Steve Cooley – District Attorney
- David Janssen – CAO
- Bruce Stanisforth – Executive Director Economy and Efficiency Commission
- Yvonne Burke – Los Angeles County Supervisor, 2nd District
- Judge Michael Nash – Edelman Children's Court
- Michael Antonovich – Los Angeles County Supervisor, 5th District
- Connie Mc Cormack – Registrar-Recorder/ County Clerk
- Cynthia Banks – Director Community and Senior Services
- Robin Toma - Executive Director Human Relations Commission
- Steffanie Maxberry – Acting Director Office of Ombudsman
- Virginia Snapp –Acting Deputy Director Los Angeles County Probation Department
- Ron Barrett – Detention Chief Los Angeles County Probation Department
- Dave Mitchell – Bureau Chief Los Angeles County Probation Department
- Jackie Tilley-Hill – Commissioner Economy and Efficiency Commission
- Ed Boks – General Manager Los Angeles Animal Services
- Marsha Mayeda – Director Los Angeles County Animal Services
- Michael Henry – Director Department of Human Resources
- Don Knabe – Los Angeles County Supervisor, 4th District
- Albert MacKenzie – District Attorney's Office, Fraud Interdiction Program
- Ellis Stanley – General Manager, City EOM
- Miguel Santana – Chief of Staff Supervisor Gloria Molina's Office, 1st District
- Zev Yaroslavsky – Los Angeles County Supervisor, 3rd District
- Dr. Gary Stern - Edison Alternative Energy Specialist
- Frank Johnston – ICE (Immigration and Customs Enforcement)

- Jitahad Imara - Acting Deputy Director, Special Services Probation Department
- Dr. Marvin Southard – Director Department of Mental Health
- Wendy Greuel - Los Angeles City Council, Mayor Pro-tem
- Gail Goldberg – Los Angeles City Planning
- Catherine Showalter – UCLA Extension, Public Policy Program

Events and Tours

- Board of Supervisor's Meeting – August 1, 2006 Civil Grand Jury recognized
- Sheriff's Department Men's Central Jail
- Sheriff's Department Twin Towers Jail
- Sheriff's Department Graduations - Classes
- California Science Center
- Sanitation Department Tour
- Sheriff's Department Pitches/North County Facility
- Los Angeles Times Plant (printing)
- Eastlake Juvenile Hall
- Edelman Children's Court – Tour and Court process overview
- Los Angeles County Coroner – Tour and Autopsy
- Peace Officer's Memorial Service – Sheriff's Academy, Whittier
- Commissioners' Leadership Conference by the Quality and Productivity Commission , Music Center
- 8th Annual Student Conference at the Los Angeles Convention Center, Sponsored by Los Angeles County Office of Education
- Sanitation Department Boat Trip
- Tour of San Pedro Pier, USS Victory and the Maritime Museum
- Operation Graduation, Sponsored by L.A. County Board of Supervisors in cooperation with: LACOE and Probation at USC Bovard Auditorium
- Juvenile Court and Community Schools Annual Academic Bowl, L.A. Center Studios, Sponsored by LACOE
- Additional functions attended by some of the jurors:
  Edmund G. "Pat" Brown Institute on Public Affairs: The California Agenda
  Public Policy Lecture Series
  1. The State of the City, December 6, 2006
  2. The State of Education in Los Angeles II, February 21, 2007
  3. California: Challenges and Opportunities, March 21, 2007
  4. Air Quality and Environmental Justice: Issues in the South Coast Air Basin: "Major Challenges Ahead" April 24, 2007 City Club on Bunker Hill
  5. "Violence and Health: A National and Regional Challenge" Hosted by the California Wellness Foundation, at CSULA on May 31, 2007

  Meeting on Los Angeles Elder Abuse, Forensic Center, 1733 Griffin Ave.
  Los Angeles May 3, 2007

In Appreciation

The Civil Grand Jury would like to express its appreciation for the service and dedication of the Sheriff's Deputies who guided us safely through the streets of Los Angeles County on our many outings in their buses. Their professional and caring demeanor was evident as they were sometimes required to wait hours for us to return.