IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

M.D., b/n/f Sarah R. Stukenberg, et al.,	§	
	§	
Plaintiffs,	§	
v.	§	
	§	Civil Action No. 2:11-CV-00084
GREG ABBOTT, in his official capacity as Governor of the State of Texas, et al.,	§	
	§	
	§	
Defendants.	§	

The Court Monitors' Update to the Court Regarding Remedial Order 20

BACKGROUND

The Court's Final Order, entered January 19, 2018, included the following remedial order:

> Within 120 days, RCCL, and/or any successor entity charged with inspections of child care placements, will identify, track and address concerns at facilities that show a pattern of contract or policy violations. Such facilities must be subject to heightened monitoring by DFPS and any successor entity charged with inspections of child care placements and subject to more frequent inspections, corrective actions and, as appropriate, other remedial actions under DFPS' enforcement framework.

M.D., b/n/f Stukenberg et al. v. Abbott, No. 2:11-cv-00084, slip. op. at 81 (S.D. Tex. filed January 19, 2018).

A. Evidence at Trial Established Poor Monitoring & Enforcement of Licensed Placements

This remedial order was born out of evidence at trial that established the ineffective monitoring and enforcement practices of Residential Child Care Licensing (RCCL).[1] The evidence established that "DFPS continues to under-regulate facilities," causing an unreasonable risk of

---

[1] At the time of the trial, RCCL was housed within the Department of Family and Protective Services (DFPS) which was a division within the Health and Human Services Commission (HHSC). The Texas legislature passed reforms in 2017 that included re-establishing DFPS as a standalone agency. However, RCCL remained housed within HHSC. Today, DFPS is responsible for monitoring and enforcing contractual provisions with providers, while HHSC – RCCL is responsible for monitoring and enforcing minimum standards set out in policy. Thus, for purposes of Remedial Order 20, DFPS is required to "identify, track and address concerns" related to contract violations, and HHSC – RCCL is required to do the same for policy violations.

harm. *M.D., b/n/f Stukenberg et al. v. Abbott*, 152 F. Supp. 3d 684 (S.D. Tex. 2015). The Court noted:

> In fiscal year 2013, CCL cited licensed facilities for 6,050 violations, but only issued 12 corrective actions and one adverse action. Over the past five years, CCL has issued four adverse actions against residential operations. CCL has closed only one facility in the past five years, but not until the fourth homicide. When confronted with recommendations on how to improve, CCL uniformly ignores them. For example, CCL employs risk analysts to determine, "the most appropriate action for reducing the risk of harm to children in a licensed facility"…CCL rarely heeds their advice, and has never followed a recommendation to impose administrative penalties…CCL also ignores its internal quality control experts at PMU. In 2011 and 2012, CCL did not follow a single license revocation recommendation.

M.D., b/n/f Stukenberg, 152 F. Supp. 3d at 803.

The Fifth Circuit U.S. Court of Appeals validated this language in an opinion issued October 18, 2018, *M.D. b/n/f Stukenberg v. Abbott*, 907 F. 3d 237 (5th Cir. 2018), finding that the problems related to RCCL's monitoring and enforcement created a substantial risk of serious harm to children in licensed placements:

> RCCL enforcement practices are also problematic. RCCL issues thousands of citations for violations per year. Of the 6,050 violations cited in 2013, however, only 12 resulted in a corrective action and only one resulted [in] an adverse action. Only one facility has been closed in the last five years – the Daystar Facility, where four children had died. Between 1993 and 2002, there were three deaths due to asphyxiation that resulted from physical restraints. There were numerous reports of physical, sexual, and psychological abuse associated with the facility. But its license was not revoked until 2011, several months after a fourth child's death was ruled a homicide by asphyxiation due to physical restraints.
>
> Daystar is a particularly tragic example. Nevertheless, studies and reports that DFPS was indisputably aware of – the State cites them in its own briefing on multiple occasions – stated that its "collaborative" approach to compliance was simply not working. This is evidenced by the fact that there is a very high rate of repeat violations, as licensees do not perceive that they will be held accountable for their malfeasance. Repeat violators are not a new phenomenon…As a result, children are left in facilities that repeatedly violate standards while the state attempts to "collaborate" with the facility…
>
> The State had knowledge of these problems. Moreover, that…inadequate enforcement policies place children at a substantial risk of serious harm seems painfully obvious.

M.D. b/n/f Stukenberg, 907 F. 3d at 267.

The Fifth Circuit remanded the case to the Court with instructions to eliminate or modify some of the other provisions included in the Court's original injunction. In the Court's modified

injunction, entered November 20, 2018, the language requiring heightened monitoring for entities with a pattern of contract or policy violations was included as remedial order 20 (RO 20). *M.D., b/n/f Stukenberg et al. v. Abbott*, No. 2:11-cv-00084, slip. op. at 4-5 (S.D. Tex. filed November 20, 2018).

B. Problems Related to Monitoring & Enforcement Persist Today

1. Enforcement of Minimum Standards by RCCL

RCCL's enforcement options include:[2]

- Corrective Action, which today includes only probation, but prior to September 2019 also included "evaluation."
- Adverse Action, which takes some action on an operation's license, and includes adverse amendment, denial, revocation, and involuntary or emergency suspension.
- Judicial Actions; and
- Monetary Actions (administrative penalties).

RCCL considers several factors when determining whether to impose an enforcement action, and which action to take. Determining whether to take enforcement action depends on: [3]

- The severity of the deficiency;
- Whether the deficiency has been repeated;
- Whether the deficiency can be corrected;
- How quickly the correction can be made;
- Whether the operation demonstrates the "responsibility and ability to maintain compliance with minimum standards, rules, and laws";
- Whether conditions must be imposed to avoid further deficiencies;
- Compliance history; and
- Degree and/or immediacy of danger posed to the health or safety of children.

HHSC published the following table to describe how RCCL determines which action to take once a decision is made to take action:[4]

---

[2] An operation may also undertake a voluntary plan of action. RCCL may also offer technical assistance rather than take formal enforcement action.
[3] 26 Tex. Admin. Code §745.8607.
[4] Texas Health and Human Services Commission, CCL Enforcement Actions, *available at* https://hhs.texas.gov/doing-business-hhs/provider-portals/protective-services-providers/child-care-licensing/ccl-enforcement-actions

Enforcement Action	What is the capability of the governing body or permit holder?	Limitation on Using This Enforcement Action?	Can risk be mitigated while the operation continues to operate?
Plan of Action	The governing body or permit holder has demonstrated all of the following: • the ability to identify risk; • accepts responsibility for correcting deficiencies; • willingness to comply; and • a history of maintaining corrections for ongoing compliance.	Yes. Licensing may only offer a Plan of Action as an enforcement action if the operation does not have history of a POA within the previous 12 months for similar deficiencies.	Yes, by following the agreed upon plan to improve compliance.
Probation	The governing body or permit holder has repeatedly demonstrated the inability to: • identify risk; and/or • make the necessary changes to address underlying issues to reduce risk. In addition, the governing body or permit holder is willing and able to make necessary corrections, with intervention from Licensing.	No. The operation may or may not have had previous enforcement actions.	Yes, by following conditions Licensing has imposed.
Adverse Amendment	The governing body or permit holder is willing and able to abide by restrictions and conditions placed on the permit.	No. The operation may or may not have had previous enforcement actions.	Yes, if the operation abides by the restrictions or conditions placed on the permit.

Enforcement Action	What is the capability of the governing body or permit holder?	Limitation on Using This Enforcement Action?	Can risk be mitigated while the operation continues to operate?
Denial and Revocation	The governing body or permit holder has repeatedly demonstrated the inability to: • identify risk; and/or • make the necessary changes to address underlying issues to reduce risk.	No. The operation may or may not have had previous enforcement actions.	No. Children will be at risk of harm if the operation is allowed to operate or continue to operate.

A preliminary analysis of relevant data[5] provided in response to the Court Monitors' first data and information request, submitted to the State on September 30, 2019, indicates that enforcement action is infrequently taken by RCCL, even when a deficiency is cited. For example, for the three-year period for which the State provided data, of the 12,555 non-sampling inspections[6] conducted by RCCL for Child Placing Agencies (CPAs), 2,936 (23 percent) resulted in at least one deficiency cited. Some received citations across multiple standards violations. However, action beyond a citation was taken in only 312 cases.[7] In 104 of these, rather than taking an enforcement action, RCCL allowed the provider to adopt a voluntary plan of action.

Similarly, of the 12,854 inspections conducted for General Residential Operations (GROs), Residential Treatment Centers (RTCs), and Independent Foster Family Homes, 2,778 resulted in at least one deficiency cited. However, only 418 resulted in some action being taken beyond a citation; 95 of these were a voluntary plan of action developed by the provider, rather than an enforcement action taken by RCCL.

Across all operations for the three-year period reviewed by the Monitors, the total number of citations is staggering. **Over the three-year period, 547 operations received at least one citation, and one operation received more than 750 during that time period. The total number of citations issued across all three years was 21,351.** Yet, only 13 operations were placed on probation between September 30, 2016 and September 30, 2019, and 25 placed under evaluation. Of the operations placed on probation, only 5 were on probation for a full year, and

[5] The September 30th request asked the agencies to provide three years of monitoring and enforcement data, from September 30, 2016 through September 30, 2019.
[6] Each year, RCCL conducts inspections for a sample of CPA foster family homes. "Non-sampling" inspections include follow-up inspections and investigations of referrals called into the abuse and neglect hotline.
[7] A "citation" is a determination that a violation of a minimum standard occurred. A citation does not, in and of itself, carry any penalty.

the remainder were on probation for less than a year. One of these was on probation for less than six months.

An analysis of Statewide Intake data (a different set of data than that discussed, above) shows similar results. Of the 7,333 referrals to Statewide Intake (the abuse and neglect hotline) between July 31, 2019 and November 30, 2019 that DFPS determined did not include an allegation of abuse, neglect, or exploitation (ANE),[8] 1,944 resulted in RCCL opening a new investigation of an alleged minimum standards violation. Of these, 81 resulted in at least one deficiency being cited, but only 6 resulted in some action being taken beyond a citation.

RCCL's Priority 1 and Priority 2 investigations of minimum standards violations involve serious allegations of risk of harm to children or involve serious injury to a child. The following chart sets out the types of allegations investigated as a Priority 1 or Priority 2 minimum standards investigation by RCCL.

Intake Priority CLASS Options	Explanation
Priority 1: Violation of the law or minimum standards that pose an immediate risk to children.	A report of a violation of a law or minimum standard places children in care at immediate risk of serious of substantial harm.
Priority 2: Injury or serious mistreatment of a child	A report that a child in care is disciplined, punished, or physically restrained in a manner that is prohibited by minimum standards, including a report that a child in care sustained a serious injury as a result of discipline, punishment, physical restraint, or other type of mistreatment prohibited by minimum standards.
Priority 2: Serious Accidental Injury	A report that a child suffered a serious accidental injury (i.e., a serious injury that is the result of an accident) and the injury may be a result of a violation of minimum standards.
Priority 2: Serious safety or health hazards	A report of a violation of the minimum standards related to safety or health that may pose a risk of substantial harm to children in care. OR A report that a person who is present at the operation has criminal or Central Registry history that may expose children in care to risk of harm. This includes:

[8] ANE investigations are conducted by DFPS.

Intake Priority CLASS Options	Explanation
	• a person who has recent arrest history that poses a risk of harm to children and whose arrest has not gone through the justice system; • a person who has recent Central Registry history and the person has not gone through due process; and • a person on the sexual offender registry whose address is an exact match to the operation's address. OR A report that an alleged unregulated operation: • meets any of the criteria above; • has a history of operating without a permit; • was previously listed, licensed, or registered and closed voluntarily or by adverse action; or • is caring for more than 12 unrelated and related children.
Priority 2: Serious supervision problems	A report of a violation of the minimum standards related to supervision that may pose a risk of substantial harm to children in care.

Despite the serious nature of these allegations, very few of the investigations of a Priority 1 or Priority 2 intake result in a citation or in any corrective action being taken. Of the 1,944 investigations discussed above, 12 were investigated as a Priority 1 and 586 – approximately 30 percent – were investigated as a Priority 2. Of these, none of the Priority 1 investigations resulted in a citation or any corrective action. Thirty-three of the Priority 2 investigations resulted in citing a deficiency and, of those, only 3 were the basis of some action beyond the citation.

Further, the data provided in response to the Monitors' data and information request indicates that during the five year period between September 30, 2014 and September 30, 2019, *not a single license was revoked* for a GRO (including RTCs) or a CPA.

The failure to appropriately enforce standards violations even when one is determined to occur may be compounded by a high investigatory error rate. The high error rate for investigations of ANE and minimum standards violations was also established at trial. *M.D. b/n/f Stuckenberg v. Abbott*, slip op. at 84 – 85 (S.D. Tex. January 19, 2018). The Fifth Circuit also affirmed these findings, noting "The record establishes that RCCL has an alarmingly high investigatory error rate." *M.D. b/n/f Stuckenberg v. Abbott*, slip op. at 39 (Fifth Cir. 2019). The very low number of inspections and investigations that result in a cited deficiency raise serious concerns related to whether inspections and investigations are appropriately identifying violations of minimum standards.

2. Contractual Enforcement by DFPS

Most minimum standards, particularly those related to health and safety, are also woven into contractual language included in the contracts that DFPS executes with providers.[9] Because there are so few deficiencies cited or enforcement actions taken by RCCL, there are few contractual enforcement actions taken by DFPS as a result of notification from RCCL of standards violations. There are also few complaints made to DFPS related to contract performance. According to data provided to the Monitors, only 45 complaints were reviewed by DFPS contracts staff between September 30, 2016 and September 30, 2019. Of those, 24 were determined to be valid.

In addition to reviewing complaints, DFPS has a risk management policy related to contractual enforcement. According to the agency's policy, the following risk factors are monitored for client service contracts by the division tasked with oversight:[10]

- Contractor growth;
- Organizational changes;
- Client safety;
- Service delivery and quality;
- Resource management; and
- Internal controls.

A risk assessment tool is used to determine which contracts will be included in annual Specialized Monitoring Plans (SMPs).[11] Monitoring may be comprehensive or targeted, depending on the risk level or score determined by the risk assessment tool. Monitoring plans are developed and conducted for the identified contractors during each fiscal year and completed by the end of the calendar year. Over the three years for which the State provided data, 153 contractors were subject to SMP.[12] In each year, the contracts included within the SMP represented 14 to 20 percent of all residential child care contracts.

When DFPS contract staff determine that a contractor has failed to live up to its obligations, DFPS may respond by requiring a corrective action plan, or may opt instead to implement a contractual remedy. In cases in which the contractual violation poses a significant harm or risk of harm to children, the agency may impose additional reporting requirements, or may take

---

[9] *See* DFPS, Comparison of Minimum Standards, Residential Contract Requirements, and Service Level Indicators, *available at* https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/comparison.asp

[10] DFPS, Policy 4.6 Risk Management (August 1, 2019).

[11] *See* DFPS, Review Reason: Risk Based, Enhanced, Complaint, Follow-Up, *available at* https://www.dfps.state.tx.us/Doing_Business/Contract_Handbook/Chapter_5/5-03-review-reason.asp

[12] The reports for each contractor on the SMP within those three years are in narrative form, and will be reviewed as part of the full reports the Monitors will file later this year.

action to reduce the services or dollars associated with the contract. Contractual remedies include: [13]

- disallowances or collection of improper payments;
- a suspension of referrals or placements;
- removal of specific services from the contract provisions;
- suspension of payment;
- placing the contractor on vendor hold; or
- a reduction of the contract amount.

THE STATE'S PROPOSED METHODOLOGY FOR COMPLYING WITH RO 20

At the first meeting between the Court Monitors and State leadership for HHSC and DFPS on September 9, 2019, RCCL and DFPS provided information related to their proposed implementation of each remedial order. The materials prepared for the meeting indicated that RCCL would use the existing policy enforcement framework to implement RO 20, but asked the Monitors for clarification related to definitions for "pattern," the timeframe for determining a pattern, and a definition for "heightened monitoring." The RCCL materials state:

> **Implementation:** Existing policy enforcement framework contained in 26 TAC Chapter 745 and CCLPPH 4500: Evaluating Risk to Children.
>
> **Compliance**: HHSC-RCCL respectfully requests clarification on the following issues in order to comply with its aspects of this Injunction:
> - How to define a pattern of minimum standards violations;
> - The timeframe requested to determine a pattern of minimum standards violations; and
> - The definition of "heightened monitoring."
>
> With such clarification, HHSC-RCCL can develop protocols to identify, to track and to address facilities with patterns of minimum standards violations.

DFPS, however, simply indicated that it was already complying with this provision of the order, stating:

> DFPS practices are in compliance with this order. If DFPS identifies a decrease in a contractor's performance, DFPS may begin with initiating a technical resolution process during which issues, barriers and potential solutions are identified. If issues persist, the DFPS Contracts division may refer the contractor for review in a Facility Intervention Team Staffing with HHSC, RCCL, RCCI and CPS. This staffing is intended to comprehensively identify possible root causes and coordinate responses from program and contracts divisions, as appropriate.

[13] DFPS, Policy 4.7 Contractor Noncompliance and Contract Remedies (July 1, 2013).

On October 7, 2019, the Monitors advised both agencies that the Court had reviewed their responses and instructed:[14]

> With respect to HHSC's Request for Clarification for Remedial Order 20, the Court directs the State to propose a specific and detailed definition of "pattern" using a retrospective analysis of nothing fewer than 5 years. With respect to heightened monitoring, the Court directs the State to propose a detailed definition of heightened monitoring that moves beyond the existing oversight and enforcement framework.

DFPS and RCCL sent their proposed definitions to the Monitors on November 1, 2019.

A. RCCL's Proposed Definitions

1. Pattern

The definition and methodology proposed by RCCL for identifying a pattern are:

> **Pattern:** A pattern is defined as a repeated and increasing occurrence of similar deficiencies within a defined time period.
>
> **Steps in identifying the pattern:**
>
> 1. Review data that has the average number of deficiencies the operation had broken out by each subchapter for the last six years.
> 2. For each subchapter, compare the number of deficiencies for the last two years to the average number of deficiencies over the last six years.
> 3. If the number of deficiencies for the last two years is two or more above the average number of deficiencies for the last six years, then there is a pattern of deficiencies.

2. Problems with RCCL definition and methodology

There are several problems with the RCCL proposed definition and methodology for identifying a pattern:

- It only compares operations to themselves.
- It only identifies a pattern where deficiencies are repeated *and increasing*.
- It only identifies a pattern if the deficiencies cited over the period of analysis are similar.
- The time periods proposed for the comparison would significantly narrow identification of operations that need heightened monitoring.

---

[14] The Monitors sent their first comprehensive data and information request to the State on September 30, 2019. In this request, the Monitors asked both agencies to provide a detailed description of how they define a pattern of contract or policy violations. Responses were due to the Monitors November 1, 2019.

Failing to use other operations as a point of comparison means that operations that have a particularly high rate of deficiencies in comparison to other, similar operations will not be identified for heightened monitoring. This is even more concerning when coupled with the requirement that deficiencies not only be *repeated* but also *increasing*. Thus, an operation with an already high rate of deficiencies will only be identified for heightened monitoring *if it gets significantly worse.*

The example set out, below, highlights the problems associated with using this methodology. This analysis draws upon data for the three-year period provided to the Monitors in response to their September 30, 2019 data and information request.

Operation A. Not Eligible for Monitoring Under Pattern Definition

Deficiencies cited 2016-17	30
Deficiencies cited 2017-18	37
Deficiencies cited 2018-19	29
Three Year Average:	32
Two Year Average:	33
Difference = 1	

Operation B. Not Eligible for Monitoring Under Pattern Definition

Deficiencies cited 2016-17	22
Deficiencies cited 2017-18	19
Deficiencies cited 2018-19	14
Three Year Average:	18
Two Year Average:	17
Difference = 1	

Operation C. Eligible for Monitoring Under Pattern Definition

Deficiencies cited 2016-17	3
Deficiencies cited 2017-18	9
Deficiencies cited 2018-19	8
Three Year Average:	7
Two Year Average:	9
Difference = 2	

In addition to the problems illustrated above, limiting the identification of a pattern to similar deficiencies would fail to address an increase in deficiencies if the deficiencies cited change. An operation could correct one area of deficiency only to get much worse in another – but these deficiencies would not be addressed through heightened monitoring until they persisted for several more years.

Last, the proposal to include six years of data in the average calculation for an operation smooths the average, increasing the likelihood that an operation will not be identified for heightened

monitoring. Similarly, using two years of data to identify the increase in comparison to the six-year average could fail to identify that an operation has had a sudden change for the worse.

3. Heightened Monitoring

Next, RCCL describes their proposal for heightened monitoring:

> **Once the pattern is identified:**
>
> 1. Conduct a targeted monitoring within 30 days. The targeted monitoring will be specific to the subchapters where the pattern has been identified. See below for heightened monitoring activities for details related to a targeted monitoring.
> 2. Review the specific deficiencies for the last two years and identify the weight of each deficiency.
> 3. Staff the operation with the supervisor to discuss the pattern(s) identified and the weights of each deficiency for the last two years.
> 4. If there are any high weighted deficiencies during the review period for a subchapter, then a Plan of Action would be staffed. The decision would be made in compliance with enforcement framework rules.
> 5. If there are three high weighted deficiencies during the review period for a subchapter, then Probation would be staffed. The decision would be made in compliance with the enforcement framework rules.
> 6. If there are three subchapters in which a pattern has been defined, then Probation would be staffed. The decision would be made in compliance with enforcement framework rules regardless of the weights of the deficiencies.
>
> **Heightened Monitoring:**
>
> CCL currently has enforcement tools such as an expedited inspection, Plan of Action, Probation, and Adverse Action. To comply with Court's direction, CCL would implement a targeted monitoring as heightened monitoring.
>
> Targeted monitoring is defined as a specific unannounced inspection targeted on a review of the subchapters where a pattern of deficiencies has been identified. The targeted monitoring must occur within 30 days of the pattern being identified.
>
> The results of the targeted monitoring would be used in actions to be taken once a pattern of deficiencies has been identified.

4. Problems with RCCL proposal for Heightened Monitoring

The primary problem with RCCL's proposal for heightened monitoring is that it fails to meaningfully strengthen the agency's existing enforcement framework to protect child safety, per the Court's instruction. The only new action – Targeted Monitoring – requires only one unannounced inspection. The description otherwise relies on the same enforcement framework that the Court and the Fifth Circuit have each determined fails to keep children safe from an unreasonable risk of harm.

The Children's Hope residential treatment center in Lubbock is a good example of inadequacies of the current enforcement regime. All three Children's Hope campuses – two in Levelland in addition to the Lubbock campus -- were placed under evaluation for six months in 2014. The focus of the conditions for the successful completion of the evaluation included providing timely background checks for staff; providing training for staff in appropriate supervision of children; maintaining appropriate child to caregiver ratios; providing training to staff in appropriate discipline techniques; appropriate inspection by staff of the building, grounds, equipment, and transportation; requiring the administrator of the operation to spend time on-site observing staff and interacting with children; providing training related to medication storage and dispensation; and a comprehensive medication review for all children in care. The facility completed the evaluation plan in October 2014.

However, by January of 2016, the facility was again identified by DFPS as having problems. Given the gravity of the safety problems identified, many of which RCCL had identified in the 2014 evaluation, DFPS suspended placements of CPS children on the Lubbock campus and on one of the Levelland campuses. All CPS children were moved from these facilities on February 1, 2016. However, even then, RCCL did not move to suspend the operation's license.

Two months later, the interim executive director of Children's Hope contacted DFPS and indicated a desire to reopen the two campuses. After considering the plan that the operation presented, including steps it had taken or would take to address the child safety concerns that led to closure, DFPS authorized a conditional lift of the placement suspension in December 2016, less than a year after children had been removed. Just two years later, in December 2018, Children's Hope – Lubbock was again placed on evaluation for many of the same or similar child safety issues that had led to earlier action by DFPS. RCCL determined the operation completed its evaluation satisfactorily in June of 2019. Yet by November 2019, the recurrence of child maltreatment at the Lubbock operation resulted in another child placement suspension for that campus. All CPS children were again removed from Children's Hope – Lubbock by December 16, 2019, and DFPS moved to terminate its contract with the operation. RCCL then indicated – finally, **five years** after the first problems surfaced – that it would revoke the license for the Lubbock campus.

Though the Levelland campus is still open, the Monitors have just learned of problems at that campus, including reports of multiple children running from care in the last week and almost daily calls from the facility to law enforcement.[15] Local media articles quote law enforcement officials who stated that one of the calls came from a staff person who had barricaded herself in the bathroom to protect herself from the children; when the officer asked where the other staff were, the staff person indicated they had all quit.[16] Children's Hope illustrates the need for monitoring and enforcement action beyond the existing framework.

B. _DFPS's Proposed Definitions for "Pattern" and "Heightened Monitoring"

[15] Kati Moody, *Local officials seek solutions for Children's Hope*, Levelland & Hockley County News Press, March 1, 2020, *available at* http://levellandnews.net/62529/2330/1/this-weeks-issuepdf
[16] Id.

DFPS has proposed an entirely separate framework for determining a "pattern" of contract violations, and heightened monitoring.

1. Pattern

The proposed definitions for pattern provided by DFPS is as follows:

> The DFPS Contracts division identifies a pattern of contract violations through contract oversight activities. To assess the operational health and quality of contracted providers, the DFPS Contracts division analyzes and acts on information from the Health and Human Services Residential Child Care Licensing division, Child Protective Services caseworkers, DFPS Residential Child Care Investigations, performance data, and financial analysts. A pattern manifests when information, obtained from these various information sources and systems indicates a negative trend in quality of services offered, and independent or collective judgment suggests the existence of a potential increase in risk to child safety or well-being. Information considered when determining whether a pattern is manifest includes:
>
> - Length of time a condition is evident,
> - Magnitude of concerns,
> - Relationships among multiple indicators (such as licensing, contract monitoring, performance measure data, CPS caseworker documentation, etc.),
> - Complexity of concerns, and
> - Demonstrated capacity for self-correction
>
> In accordance with policy 4.6 and 4.7, when assessing a potential pattern of risk and determining appropriate actions, DFPS considers current and historical information including:
>
> - Contractor performance on contract performance measures
> - The results of third party reviews of contractor compliance with service level requirements
> - Concerns raised by program or other individuals
> - Residential Child Care Investigations and Dispositions
> - Residential Child Care Licensing Investigations and Minimum Standard Violations
> - Audits
> - Cost reports
> - Annual contract monitoring results
>
> *Note: DFPS may take action even when a pattern or history of contract violations does not exist, such as when there is a serious injury to a child.*
>
> Often, the contract manager initially identifies an issue, when he/she is notified of a Contractor' failure to self-correct Service System review requirements. The contract manager collects information concerning the Contractor's compliance history, then refers any concerns for a Facility Intervention Team Staffing with Health and Human Services

Commission Residential Child Care Licensing, DFPS Residential Child Care Investigations and DFPS Child Protective Services staff to comprehensively identify possible root causes and coordinate responses from program and contract divisions, as appropriate (e.g., targeted technical assistance, corrective action plan, contract remedies, contract termination).

2. Problems with DFPS definition and methodology

Though DFPS references a "negative trend," it fails to provide any objective measure or methodology for determining when a negative trend exists. DFPS also does not include any time period for the analysis, nor any methodology for consideration of the list of information to be "considered" when making a determination. The agency refers to "independent or collective judgment," underscoring that this is largely a subjective process.

3. Heightened Monitoring

DFPS provided the following with regard to its proposal for heightened monitoring:

Depending on the circumstances, the DFPS Contracts division deploys a number of tools to evaluate Contractor compliance violations and risks of non-compliance:

- During application and provisional contracting, DFPS uses a contract application vendor screening process to determine administrative, programmatic, and fiscal readiness. Activities include evaluating historical performance prior to issuance of a provisional contract, assessing the applicant's internal controls, vendor status to do business in the State of Texas, and ability to demonstrate reasonable compliance with the service level indicators. During the provisional contracting period, the Contractor's performance and risks identified during the application screening process drive the level of oversight required and ultimately, the decision whether to enter into a longer term contract.
- Post provisional contract, contract staff utilize an Annual Risk Assessment Instrument (RAI)to guide risk categorization that identifies the contractors to be monitored. Under Contract Policy, DFPS uses the risk scores in conjunction with contract manager input to create the Statewide Monitoring Plan (SMP), which is a list of the highest risk contracted providers the Contracts division must monitor. The Contracts division then conducts onsite or desk review contract monitoring for each provider identified on the SMP. In addition, the Contracts division has developed new performance measures and implemented a system of incentives and remedies to help drive better quality from its contracted providers.

Community Based Care System

- The Community-Based Care (CBC) model focuses on achieving outcomes for children and families through the competitively selected contractor. First, DFPS conducts a formal readiness review process to ensure that contracted

procedures, systems, and staffing functions can assume responsibilities prior to implementation. Second, DFPS has established a number of performance indicators and data points that measure the overall health of the child welfare system of services. A multi-disciplinary team (consisting of program, contract, data, IT, legal, and fiscal experts) conduct continual oversight activities by reviewing these indicators and data points to assess the overall health of the CBC and child welfare system. If performance indicators and data begin to decline, DFPS will intervene through a series of progressive intervention actions tailored to reverse the corresponding decline in performance. In addition to performance and data monitoring, the multi-disciplinary team conducts a traditional, formal on site contract and program monitoring review on an annual basis. Lastly, the Single Source Continuum Contractor (SSCC) is responsible for routine direct service provider monitoring similar to the function performed by the Contracts division in the DFPS Legacy System.

- At any time, if the DFPS Contracts division identifies a decrease in a contractor's performance, it may begin progressive intervention actions such as initiating a technical resolution process during which issues, barriers and potential solutions are identified, and escalating to corrective action plans to identify and resolve root causes through a coordinated effort between the parties.

Immediate Safety Concerns

- When a safety concern is identified, any member involved in the oversight and enforcement of a Legacy or CBC contract may refer the contractor for review in a Facility Intervention Team Staffing (discussed previously in this document).
- DFPS intervenes in FITS issues through a series of potential actions, including but not limited to, safety reviews, requiring the provider to hire an independent consultant, placement hold, and, most drastically, termination of the provider contract and removal of all children and youth. When a decision is made to discontinue providing services and terminate the contract, DFPS manages risk to the greatest degree possible through coordinated transition planning.

Moving beyond the existing oversight and enforcement framework described herein, DFPS will take the following additional actions:

- The DFPS Contracts division plans to dedicate staff who will specialize in working with new applicants who wish to contract with DFPS and provisional contractors. These specialized staff will conduct readiness assessment activities to better identify and address risks and weaknesses earlier in the pre-contracting process which in turn will further inform the decision of whether or not to contract with the applicant, or post-contract award, when new providers can often fail or perform poorly as they ramp up services and gain experience as a provider. These specialized staff would continue overseeing the new contractor's performance through the 18-24 month provisional contracting

period. After this time, another contract monitor may assume long-term responsibility for the contract.

- The DFPS Contracts division plans to increase the number of contracts monitored beyond the SMP. The Contracts division will hire additional contract monitors in order to increase the number of contracted providers monitored by DFPS. Increasing the number of on sight heightened monitoring increases DFPS' presence in facilities.

In addition to these activities discussed herein, the DFPS Office of Data and Systems Improvement (DSI) will evaluate no fewer than five years of performance history through a structured, automated retrospective analysis of data and information oversight activities that looks for patterns that cannot be easily identified by a single individual reviewing the same information. DSI will convert the results of its analyses into accessible reports for Contract staff, highlighting significant patterns and trends so staff can proactively identify which contractors to target for additional follow-up and heightened monitoring and support. As Contract staff engage contractors around the DSI analyses and reports, DSI will provide support in using data to evaluate contractor explanations around likely root causes for identified issues and in tracking the effect of any improvements and changes contractors make.

4. Problems with DFPS Proposal for Heightened Monitoring

DFPS's plan does little to move meaningfully beyond the existing structure of monitoring for contractual violations, aside from increasing the number of contracts monitored through the SMP. The only new proposal was to dedicate staff to work with new applicants.

Again, using Children's Hope as an example of the failures of the current framework, while DFPS moved to suspend placements upon learning of problems in 2016 and again in 2019, it was also quick to lift those suspensions and resume placements. And though they quickly suspended placements in 2016, they did not move children still in the facility until two unannounced visits had been made to the Lubbock campus and three were made to the Levelland campus, delaying action for a week. This was true despite the report from the first CPS workers who made the initial unannounced visits that conditions they observed at the campuses included:[17]

- Food being served to the children that was out-of-date and had grown mold;
- Complaints from children that they were not getting enough to eat, and were not able to shower;
- Children's reports of injuries caused by improper restraints, as well as outcries of physical abuse including being kicked and choked;
- Mouse droppings in the kitchen and bedrooms and dead roaches throughout the facility;
- Children with diabetes who had to be hospitalized because the facility did not have appropriate testing equipment;
- What appeared to be feces smeared on walls in some rooms;

[17] DFPS report to the Monitors regarding Children's Hope, provided in response to the Court's order of February 21, 2019.

- A report that a child who had self-harmed and was bleeding was not being treated because, according to staff, the child had refused treatment;
- Overflowing garbage cans, dirty kitchen and bathroom floors, mildew growing in showers and the smell of methane gas coming from one of the bathrooms.

Subsequent visits not only confirmed these problems, they found additional threats to children's safety. While moving the 86 children and finding other placements could not have been easy, requiring multiple unannounced visits before that decision was made delayed action and planning.

In 2019, after Children's Hope – Lubbock completed its RCCL Evaluation in June (discussed above), DFPS contracts conducted a monitoring visit in late July. The visit from DFPS contracts staff simply ended with recommendations for targeted technical assistance and training, without raising any of the issues that just four months later led to another placement hold and, ultimately, contract suspension.[18] By November 2019, DFPS's safety checks revealed:[19]

- Children who reported feeling unsafe in the placement;
- Disengaged staff;
- Issues with bullying, and staff failing to intervene;
- Children reporting child-on-child sexual aggression;
- Children reporting getting hurt in restraints; and
- Night staff sleeping during shifts.

In addition to their failure to meaningfully move beyond the existing monitoring and enforcement framework, the Monitors are concerned that the two agencies described two different entirely definitions of pattern, and failed to identify a single opportunity to work together to develop a cohesive and integrated plan for heightened monitoring. Though the agencies reportedly now engage in bi-monthly as well as emergency joint "Facility Intervention Team Staffing" (FITS) meetings to discuss provider issues and information related to serious incidents, neither of the agencies' plans included this process as part of their proposed plan for heightened monitoring. Communication between the two entities is critical to ensuring child safety concerns are identified and addressed quickly and effectively, whether through licensing enforcement mechanisms or contractual enforcement.

C. The Monitors' Recommendation to the Court Regarding Definitions for "Pattern" and "Heightened Monitoring"

After reviewing the agencies' proposals, the Court directed the Monitors to draft a proposed definition and methodology for pattern and heightened monitoring to share with HHSC and DFPS for feedback. The Monitors sent an alternative proposed definition to the State for feedback on February 4, 2020.

---

[18] DFPS, Fiscal Year 2019 Residential Child Care Final Contract Monitoring Report Childrens Hope Residential Services, Inc (August 27, 2019).

[19] DFPS report to the Monitors, *supra* note 17.

During a telephonic hearing on February 12, 2020, the Court ordered the State to provide feedback on the Monitors' proposed definitions and methodology by February 19, 2020. In a subsequent telephonic hearing on February 21, 2020, the Court ordered the Monitors to provide their proposed definition and methodology to the Court by noon on Friday, February 28, 2020. The Monitors shared their proposed methodology and definition with the Court, along with the State's written feedback. The Court asked the Monitors to file this report, setting out the agencies' proposed frameworks and the reasons the Monitors recommend an alternative, unified framework.

Following consultation with HHSC and DFPS involving written and verbal feedback, the Monitors recommend the following framework for implementation of Remedial Order 20.

Pattern:

A pattern is defined as a high rate of contract and standards violations for at least three of the last five years.

Steps in identifying the pattern:

1. Each agency shall review data for the rate of contract and standards violations, including confirmed findings of abuse and neglect, for the last five years. The rate is calculated using the number of violations divided by the operation's capacity multiplied by 10 (Number of contract or standards violations/capacity X 10).
2. For each of the last five years, compare the operation's rate of violations to the combined rate of violations for all operations of similar size (small, medium, or large) and service type (basic general residential operation, residential treatment center, child placing agency, and independent foster family and group homes).
3. If the operation's rate of violations rated medium, medium-high, or high is above the combined rate of violations rated medium, medium-high, or high for operations of similar size and service type for three of the last five years, then there is a pattern of violations.
4. Each agency shall inform the other of all operations identified as having a pattern of deficiencies.

Operation Size:

Small operations:	Those with a capacity of 20 or fewer children or, for CPAs, 20 or fewer open foster homes;
Medium operations:	Those with a capacity of 21-50 children or 21- 50 open foster homes; and
Large operations:	Those with a capacity of more than 50 children or more than 50 open foster homes.

Operation Service Type:

Basic General Residential Operation
General Residential Operation – Residential Treatment Center
Child Placing Agency
Independent Foster Family and Group Homes

Heightened Monitoring

When an operation is identified for heightened monitoring, a Facility Intervention Team Staffing (FITS) is scheduled within 5 days. The intervention team is made up of staff from, at least, RCCL, DFPS CCI, DFPS Contracts, and CPS.

During the FITS, the team will review:

- Any trends for the operation identified as a result of the 5-year retrospective analysis.
- Any monitoring plans or corrective or enforcement actions for the operation in the last 5 years;
- Any risk analyses conducted by RCCL or DFPS for the operation in the last 5 years.

If the review reveals events that implicate an ongoing concern for the health and safety of children, the intervention team will develop a safety plan and temporarily suspend placements until all concerns for children's health and safety have been addressed. This must be documented in CLASS.

The FITS team is responsible for developing a heightened monitoring plan that:

- Outlines a coordinated response from RCCL & DFPS, including a list of staff from both agencies who will serve on the heightened monitoring team for the operation;
- Describes a detailed and specific plan addressing:
    - The pattern of policy violations that led to heightened monitoring;
    - Any barriers to compliance identified during a review of previous corrective or enforcement actions or risk analyses;
    - Any technical assistance needed by the operation from FPS, RCCL, or a third party;
    - The steps the operation must take to satisfy the plan.

While an operation is on heightened monitoring, RCCL and DFPS will share responsibility for at least weekly unannounced visits to the operation, and any placements of PMC children must be directly approved by the Associate Commissioner of CPS.

The heightened monitoring plan will remain in place for at least one year and until:

- the operation satisfies the conditions of the plan;
- at least six months' successive unannounced visits indicate the operation is in compliance with the standards and contract requirements that led to heightened monitoring; and
- the operation is not out of compliance on any medium-high or high weighted licensing standards.

After the operation is released from the plan, DFPS and RCCL will coordinate to make at least three unannounced visits in the three months following the release from the plan, and the heightened monitoring team will continue to track intake data for the operation for six months to ensure it does not lose progress made during monitoring.

If the operation does not come into compliance with the plan during the heightened monitoring period, DFPS and RCCL will identify one or more of the following penalties:

- suspension of placements;
- imposition of fines;
- suspension or revocation of the facility or CPA's license;
- termination of the contract.

The heightened monitoring plan, unannounced visits associated with the plan, and progress toward meeting the plan must all be documented in CLASS. Caseworkers for PMC children in operations under heightened monitoring must be made aware of the monitoring.

CONCLUSION

In their second set of feedback to the Monitors, the State asks for more time and more discussion to develop the definitions and methodology for establishing a heightened monitoring framework. The agencies urge a more "nuanced" approach and a staged proposal, arguing that they cannot implement the Monitors' proposed framework without additional time and resources.

More time would mean more children subjected to an existing practice that both the Court and the Fifth Circuit found creates an unreasonable risk of harm to children in care. The children who have cycled in and out of Children's Hope in Lubbock – and who are today in the Levelland facility that is still open despite significant reports of problems -- are a vivid example of the cost associated with continuing to engage a framework that fails to meaningfully address contractual and minimum standards violations.

The agencies also shared concerns that the Monitors' recommended framework would not allow them to be nimble if they identified a new issue at an operation that posed an immediate safety threat to children. The Monitors do not intend the heightened monitoring framework to completely displace any action the agencies may need to take to keep children safe. This framework should be considered a floor, not a ceiling.