#### The Great Seal of Georgia

**Knowledge Management Section**

**January 2016- June 2016**

**Quality Assurance Trend Report**

**Steven Reed, Section Director**

**Quality Management**

**Kelley Kent, QA Unit Manager**

**CWQA Unit**

**Donna Jarrard, QA Reviewer**

**Elaine Manning, QA Reviewer**

**Lori Parris, QA Reviewer**

**Lisa Plank, QA Reviewer**

**Terri Speir, QA Reviewer**

**Tina Truett, QA Reviewer**

**Kelly Dennis, QA Reviewer**

**CWCQI Unit**

**Mercedes Bailey, CQI Specialist**

**Charmaine Brent, CQI Specialist**

**Cynthia Clayton, CQI Specialist**

**Angel Gooddine-Dunham, CQI Specialist**

**Ranita Webb, CQI Specialist**

Table of Contents

[I. PURPOSE 3](#_Toc456615319)

[II. METHODOLOGY 4](#_Toc456615320)

[III. ANALYSIS OF REVIEW FINDINGS 5](#_Toc456615321)

[IV. OUTCOMES/ FINDINGS 10](#_Toc456615324)

[SAFETY OUTCOMES 10](#_Toc456615325)

[Safety Outcome 1- Children are first and foremost protected from abuse and neglect 10](#_Toc456615326)

[Safety Outcome 2-Children are safely maintained in their homes whenever possible and appropriate 14](#_Toc456615327)

[PERMANENCY OUTCOMES 20](#_Toc456615328)

[Permanency Outcome 1-Children have permanency and stability in their living situations………………………………………………………………………………….](#_Toc456615329)19

[Permanency Outcome 2- The continuity of family relationships and connections is preserved for children 28](#_Toc456615331)

[WELL-BEING OUTCOMES 38](#_Toc456615332)

[Well-Being Outcome 1-Families have enhanced capacity to provide for their children’s needs 38](#_Toc456615333)

[Well-Being Outcome 2- Children receive appropriate services to meet their educational needs 53](#_Toc456615334)

[Well-Being Outcome 3-Children receive adequate services to meet their physical and mental health needs 56](#_Toc456615335)

[V. Areas of Concern/Critical Issues 63](#_Toc456615336)

[VI. Stakeholder Feedback 66](#_Toc456615337)

[VII. Continuous Quality Improvement 69](#_Toc456615340)

[VIII. Appendix 71](#_Toc456615341)

# I. PURPOSE

The Quality Assurance (QA) Unit conducted an ongoing Child and Family Service Review (CFSR) beginning January 1, 2016 through June 30, 2016. The CFSR Reviews were conducted to evaluate the quality of child welfare services provided to children and families. This document presents the findings of this CFSR assessment of the state’s performance with regard to seven child and family outcomes and the regions’ systemic factors.

The findings were derived from the following documents and data collection procedures:

* A review of **150** (90 Permanency, 30 Family Preservation, 30 Family Support) social services cases in all regions.
* The input of **220** internal and external stakeholders was incorporated into this report. Case specific interviews and/or surveys were conducted in counties and at the region level with community stakeholders, including but not limited to: children; parents; foster parents; social services supervisors; social services case managers; DFCS administrators; collaborating agency personnel; service providers; court personnel; school and public health personnel; and attorneys.
* Information reflected in state, regional and county level data reports.

|  |  |
| --- | --- |
| **Region** | **Number of Case Reviewed (All Programs)** |
| **1** | **16** |
| **2** | **3** |
| **3** | **14** |
| **4** | **11** |
| **5** | **11** |
| **6** | **7** |
| **7** | **3** |
| **8** | **8** |
| **9** | **3** |
| **10** | **10** |
| **11** | **10** |
| **12** | **12** |
| **13** | **21** |
| **14** | **21** |

Regional data from the CFSR are combined to produce State Trend Reports, and the data are included in the State’s Annual Progress Service Report (APSR) required by the Federal Administration of Child and Family (ACF) as part of the State’s Child and Family Services Plan (CFSP). Additionally, CFSR findings are used by local agency leaders and practice partners to improve child welfare practices which will lead to better outcomes for children and families receiving child welfare services in Georgia.

# II. METHODOLOGY

To conduct the review, the current CFSR On-site Review Instrument and Federal Online Monitoring System (OMS) were utilized, and case-specific interviews were conducted on all cases reviewed to evaluate the quality of casework and adherence to policy as related to safety, child and family well-being and permanency planning for children.

Additionally, a standardized questionnaire was utilized and interviews conducted by the QA Review Team in order to assess the agency’s relationship with stakeholders in the community and its effectiveness in helping children move toward permanency.

Cases were randomly selected by zones. A rolling statewide sample was drawn from active cases beginning with the period of June 1, 2015 to November 30, 2015 and moved forward one month for each sample pulled during the review cycle (i.e. the second sample would be pulled from July 1, 2015 to December 31, 2015 and so on).

All program activity (Family Support, CPS Investigations, Family Preservation, and Permanency) in selected case records was reviewed. An overall rating of Strength or Area Needing Improvement (ANI) was assigned to each of the 18 items. In order for the state to be in substantial conformity with a particular item, **90%** of the cases reviewed must be rated as a strength.

State performance on the seven outcomes is evaluated as Substantially Achieved, Partially Achieved and Not Achieved. In order for the state to be in substantial conformity with a particular outcome, **95%** of the cases reviewed must be rated as having substantially achieved the outcome.

Although the statewide sample was randomly selected by zones, Regional and District data included in the report are reflective of the reconfigured regions and established Districts which were implemented in July 2015.

# III. ANALYSIS OF REVIEW FINDINGS

**Demographics of cases**

Figure 1

Of the 150 cases reviewed, there were a total of **245** children (0-18 years) served by the Division. The race and ethnicity of the children served included 112 African American, 91 White, 26 Hispanic, 14 Bi-Racial, one Pacific Islander and one Asian (Figure 1).

Figure 2

Of the 245 children, there were **114 (47%)** females and **131 (53%)** males represented in the statewide sample (Figure 2). From the sample, **90** children were in foster care, while the remaining **168** children were served through in-home services (Family support and Family Preservation).

The primary reason for agency involvement with the 150 cases included neglect, physical abuse, emotional abuse, medical neglect and sexual abuse. In addition, most of the cases were complex and had multiple reasons for agency involvement including, but not limited to: mental health issues by parents and children; substance abuse and/or domestic violence issues; physical health of the parents; behaviors of the children; and Department of Juvenile Justice involvement and/or abandonment by their parents. Of the 150 cases reviewed, approximately **65** (**43%**) involved some form of substance abuse issues by parents. Domestic violence was also present in approximately **28** **(19%)** of the case reviewed.

**Review Findings:**

For the first six months of 2016 (January 2016 to June 2016), a case review of the seven overall outcomes and 18 items was conducted in all regions within the state. Based on review findings, there continued to be minimal progress in the achievement of items and two overall outcomes (Well-Being 1 and 2) have declined since the Round 3 Federal CFSR Review conducted from April 2015 to September 2015.

The current review criteria specifically focused on the quality of the initial and ongoing case practice with families to improve overall family functioning as it related to safety, permanency and well-being, An emphasis was placed on the initial and ongoing assessment phase, as well as the initial and ongoing service provisions and monitoring.

**Performance Improvement Plan (PIP) Goals**

Based on Georgia’s Round 3 Federal Child and Family Services Review conducted in 2015, PIP performance goals were established by the Children’s Bureau. The chart below (Figure 3) provides a snap shot of Georgia’s performance in moving toward the accomplishment of the identified PIP goals for Items 1, 2, 3, 12, 13, 14 and 15.

It should be noted a six month period under review was utilized during the January 2016 to June 2016 review cycle and the current performance data will not be used in measuring PIP goal accomplishment.

PIP goal performance data will be reported to our federal partners beginning with the July 2016 reviews, after returning to a 12 month review period.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child and Family Services Review (CFSR) Round 3 Georgia: Program Improvement Plan (PIP) Goals Comparison** | | | | |
| **CFSR Items Requiring Measurement** | **Item Description** | **PIP Baseline**  **(CFSR Findings)** | **State Performance as of June 30, 2016** | **PIP Goal** |
| **Item 1** | Timeliness of Initiating Investigations of Reports of Child Maltreatment | 65.9% | 70% | 72.4% |
| **Item 2** | Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care | 58.7% | 78% | 68.0% |
| **Item 3** | Risk and Safety Assessment and Management | 43.3% | 45% | 48.5% |
| **Item 12** | Needs and Services of Child, Parents, and Foster Parents | 24.6% | 19% | 29.3% |
| **Item 13** | Child and Family Involvement in Case Planning | 41.6% | 47% | 47% |
| **Item 14** | Caseworker Visits With Child | 59.3% | 68% | 64.5% |
| **Item 15** | Caseworker Visits With Parents | 31.1% | 40% | 36.2% |

Figure 3

Based on the State’s current performance (Figure 3), Items 2, 14 and 15 currently surpasses the PIP target goals, while Item 13 met the goal and Items 1, 3 and 12 failed to meet the targeted PIP goals.

***The State did not meet the federal definition of Substantial Conformity for any of the overall seven outcomes (a rating of 95%) or for any of the 18 items reviewed (a rating of 90%).*** The highest performance was found for the following items:

* Item 4- Stability of foster care placement, which had a **71%** strength rating; and
* Item 7- Placement with siblings, which had a **71%** strength rating

The State’s lowest performance was with:

* Item 11- Relationship of child in care with parents rating at **36%**
* Item 12- Needs and services of child, parents and foster parents rating at **19%**
* Item 18- Mental/Behavioral Health of the Child which rated at **27%**

Systemically, many regions continued to report staff turnover, newly hired staff learning their current roles, and increases in case load sizes as contributing factors which impacted the ongoing assessment of children’s risk and safety. Many Regional support staff, county directors, administrators and supervisors reported carrying caseloads in addition to their regular job duties.

Many families had multiple case managers during the period under review which often resulted in the cases remaining stagnant and not moving toward safety and risk reduction and/or permanency.

The trends identified during January 2016 through June 2016 review cycle identified as State-wide opportunities for improvement remained as follows:

## Lack of Adequate Risk and Safety Assessment (including service provision, collateral contacts and quality contacts and engagement with parents and children)

Some of the more frequently identified issues identified by reviewers included:

* Insufficient frequency and/or quality of case manager contacts with children and parents
* Lack of quality initial and ongoing risk and safety assessments
* Lack of assessment/screenings for and contacts with other household members/caregivers, and insufficient contacts with relevant collaterals
* Lack of implementation and monitoring of needed interventions and services.
* Lack of case planning with families

Services were often “generic” and not individualized to meet the needs of the family. For example, parents would be referred to parenting classes, without specific details on what areas the parents needed to improve on (i.e., parenting a teenager, learning to meet the needs of a special needs child, learning to address issues of a medically fragile child, etc.). In many instances, the lack of quality contact and engagement of the families served had a negative impact on service provision.

In the majority of cases, initial assessments for services were completed, however results from the assessments were not received by the agency and no follow up had occurred. In addition, when assessments were received, recommended services/interventions often were not implemented or were severely delayed before implementation. In addition, the agency did not make collateral contacts with service providers to determine family participation, progress made, behavioral changes or effectiveness of services.

Documentation and case specific interviews did not consistently support regions adequately addressed or identified all concerns and risk issues, and there appeared to be a lack of recognition of child vulnerabilities and diminished parental capacities. It should also be noted that appropriate directives or recommendations to facilitate progress were often not given during a majority of supervisory case staffings. Too often staffing documentation was a summary of the case activity for the month and did not provide follow up from previous staffings or directives to progress the case toward reducing safety threats and/or achieving permanency.

# Lack of establishing appropriate and timely permanency plans/meeting ASFA timeframes

* ASFA timeframes continued to be an area where improvement is needed in regards to Permanency Outcome 1. There was a failure to ensure that permanency plans were approved by the court in a timely manner, that approved permanency goals were appropriate for the child based on case circumstances, that services were provided in a timely manner, and that Termination of Parental Rights petitions were filed in a timely manner
* Court continuances, the lack of court orders in case files/SHINES and the delay by the county to request approval of a new permanency goal when the current goal was no longer appropriate affected the timely approval of permanency goals
* Concurrent planning was often not utilized when warranted on cases. When concurrent planning was implemented, often the second plan was used as a “back up” instead of working both plans consistently throughout the period under review

# IV. OUTCOMES/ FINDINGS

## SAFETY OUTCOMES

### Safety Outcome 1- Children are first and foremost protected from abuse and neglect

The purpose of this assessment was to determine whether responses to all accepted reports of child maltreatment received during the period under review were initiated, and face to face contact with the child(ren) made within the assigned response time.

Figure 4

**Item 1-Timeliness of initiating investigations/family support assessments of child maltreatment** rated **70%** substantially achieved for January 2016 through June 2016 (Figure 4). This was slightly higher than CFSR findings which rated Item 1 at **66%**.

A total of 80 applicable cases were reviewed (initial report received and assigned for Investigation or Family Support during the period under review) for Safety Outcome1.

Timeliness of initiating investigations occurred when face to face contact was made with all victim children identified in the intake report, and age appropriate children were interviewed within the assigned response time.

The item was rated as an Area Needing Improvement when diligent efforts were not made to initiate the assessment and have face to face contact and interviews (or observations of non-verbal children) with all identified maltreated children within the assigned response time. There were no cases where the failure to meet the response time were due to circumstances beyond the control of the agency.

Issues that contributed to the agency’s failure to substantially achieve this item included the following:

* Failure to initiate the investigation or assessment in a timely manner (i.e. not initiating the case until the last day of the response time, or not until after the response time had been missed)
* Failure to make concerted efforts to locate the identified victim children (i.e. making contact with the children at school when home visits were unsuccessful)
* Not interviewing all alleged children identified in the intake report (i.e. contacting/interviewing the primary victim but not the siblings who were also alleged to be victims)
* Failure to identify all victim children in the intake

High caseloads were most often cited as the reason for the agency’s failure to meet response time.

Figure 5

Comparing regional performances, Regions 6, 7 and 10 rated at **100%** substantially achieved with Regions 1 and 8 rating at **40%** and Region 12 at **37%** substantially achieved (Figure 5). In regions that received lower ratings, there was no documentation of concerted efforts made to meet response times, and interviews did not support efforts being made.

Figure 6

When ratings were broken down to the different program areas (Figure 6), Family Support cases rated at **50%** substantially achieved, Family Preservation cases rated **82%** substantially achieved, and Permanency cases rated at **80%** substantially achieved for Safety Outcome 1.

Out of the 24 cases where response time was not met, 17 of those (71%) were Family Support and seven cases (29%) were Investigations.

### Safety Outcome 2-Children are safely maintained in their homes whenever possible and appropriate

Overall Safety Outcome 2 encompasses two items: Item 2- Services to family to protect children and prevent removal or re-entry into foster care; and Item 3- Risk assessment and safety management.

Figure 7

Safety Outcome 2 continued the upward trend rating at **45%** substantially achieved for the January 2016 to June 2016 reviews. (Figure 7). This was a slight increase from the CFSR Findings where Safety Outcome 2 rated at **43%**.

Figure 8

Overall, Region 2 rated the highest at **100%**, with Region 6 rating at **71%** and Region 10 at **70%**. Region 9 rated the lowest at **0%**. (Figure 8)

Figure 9

Permanency cases reviewed rated **47%** substantially achieved, Family Support cases rated **60%** substantially achieved, and Family Preservation cases rated **27%** substantially achieved for Safety Outcome 2. (Figure 9).

**Item 2- Services to family to protect children and prevent removal or re-entry into foster care** was rated a strength when appropriate services were provided to mitigate safety concerns and ensure children could safely remain in their home.

There were a total of 41 applicable cases and this item rated at **78%** strength, up from **59**% during the CFSR review. In 21 of the applicable cases rated as a strength (**51%**), children appropriately entered foster care without safety related services having been provided to ensure their safety.

This item was rated as an Area Needing Improvement when the agency failed to provide appropriate services to address identified safety issues for children and ensure their safety, such as services to address domestic violence in the presence of children, and parent/caregivers’ untreated substance abuse and/or mental health issues.

The most frequently cited concern was the lack of domestic violence services when it was an identified safety issue. Other concerns were a failure to refer or initiate substance abuse or mental health treatment, and a failure to assist families in securing basic needs such as housing and food.

Figure 10

As noted in Figure 10, Regions 1, 2, 3, 4, 5, 6, 7, 9, 10 and 13 all rated **100%** strength for Item 2. Region 8 rated **25**% and Regions 11, 12, and 14 rated between 50% and 71%.

Figure 11

Permanency cases rated **88%** strength, Family Support cases rated **50%** strength and Family Preservation cases rated only **20%** strength for Item 2. (Figure 11).

The substantial difference in ratings between Permanency and Child Protective Services (Family Support and Family Preservation) cases for Item 2 can be attributed to Permanency cases rating higher because immediate action was usually taken to protect the child (i.e. foster care), whereas in Child Protective Services (CPS) cases the children often remained in the home with noted safety concerns.

**Item 3- Risk assessment and safety management** received an overall **45%** strength rating with all 150 cases reviewed being applicable. This was an increase from the CFSR review where Item 3 rated at **43**%. The purpose of this assessment was to determine whether, during the period under review, the agency made concerted efforts on a continual basis to assess and address the risk and safety concerns for children in their own homes or while in foster care. It should also be noted that Item 3 now includes recurrence of maltreatment, which in previous CFSR rounds was captured under Safety Outcome 1.

Figure 12

Region 2 rated at **100%** substantially achieved for Item 3. The next highest ratings were Regions 6 and 10 who were at 71% and 70% respectively. Regions 4, 8, 9 and 12 had the lowest ratings, with ratings ranging from 0% to 27% for Item 3. (Figure 12)

The regions who rated higher in Item 3 made regular contacts in the home, had private conversations with the family members, assessed all household members and caretakers for the children, made meaningful and relevant collateral contacts, and addressed safety concerns brought to their attention.

Figure 13

Family Support cases rated highest in Item 3, with **60%** substantially achieved. Permanency cases rated at **47%** and Family Preservation at **27%**. (Figure 13)

The agency conducted accurate initial assessments of risk and safety concerns in **52%** of 68 applicable cases. But in the ongoing assessment of risk and safety, it was only accurate in **45%** of the 133 applicable cases. When safety plans were needed, they were developed and monitored, including monitoring the family’s engagement with safety related services, in **34%** of the 41 applicable cases.

Also assessed were safety concerns in the children’s foster home or placement facility and if they were adequately addressed. There were no concerns in foster home placements that were not adequately addressed in **90%** of the 90 applicable cases reviewed. There were no concerns for children in foster care during visitation with parents that were not adequately addressed in **88%** of the 68 applicable cases.

Some of the more frequently identified issues negatively impacting this item were:

* Insufficient frequency and/or quality of case manager contacts with children and parents
* Lack of home visits/ foster home visits
* Lack of assessment/screenings for and contacts with other household members/caregivers
* Insufficient contacts with relevant collaterals
* Failure to engage/assess step fathers/ paramours
* Failure to fully address present and newly identified concerns
* Insufficient supervisory oversight as indicated by lack of quality staffings and supervisory approval for closure in cases where all concerns had not been fully addressed
* Failure to review and consider CPS history
* Lack of a safety plan when there were identified safety/risk concerns and
* Repeat maltreatment

## PERMANENCY OUTCOMES

### Permanency Outcome 1-Children have permanency and stability in their living situations focused on the establishment and achievement of permanency goals for children in foster care and stability of foster care placements. The items comprising Permanency Outcome 1 are: Item 4- Stability of foster care placement; Item 5- Permanency goal for child; and Item 6- Achieving reunification, guardianship, adoption or other planned permanent living arrangement.

Figure 14

### Permanency Outcome 1 was substantially achieved in 21% of the 90 cases reviewed from January 2016 to June 2016 (Figure 14). Improvement was noted for Permanency 1 in comparison to the CFSR review which rated at 14%.

Figure 15

As indicated in Figure 15, Permanency 1 continued to be an overall challenge for the regions. Region 9 achieved the highest strength ratings at **50%**. Regions 2, 6, 7 and 8 had a rating of **0%**.

**Item 4- Stability of foster care placements** was rated at **71%** strength in the 90 applicable cases. Cases were rated a strength based on two elements:

* there were no moves during the period under review or any moves were planned and made to meet the child’s best interests;
* the child’s current or most recent placement was stable

Based on statewide review data, of the 90 applicable cases rated, **41%** (17 of 41 applicable cases) noted placement changes were planned by the agency in an effort to achieve the child’s case goals and/or meet the needs of the child, while **93%** (84 of 90 cases) of those cases indicated the child’s most recent or current placement setting was stable.

In looking at the stability of placements, reviewers noted foster home issues (including policy violations or reports of abuse in the foster home), inadequate assessment of the child’s needs, the lack of appropriate resource homes and/or the use of temporary placements that resulted in unplanned placement moves and placement instability. It is also noted, that continued practice, in some urban regions, for children to initially be placed in a temporary placement when they enter care had a negative impact on this item.

Insufficient local foster home resources was an identified concern for most regions. This was also recently recognized by State Leadership, and there has been increased focus on Resource Development.

Figure 16

A breakdown by regions shows Regions 2, 7, 9 and 10 all at **100%** substantially achieved for Item 4, while Region 4 rated the lowest at **43%**. (Figure 16).

Figure 17

Out of the **90** children in foster care reviewed, **49** (**54%)** only experienced one placement, **23** **(26%)** had two placements (17 of 23 were planned moves in the child’s best interests), and **18 (20%)** experienced three or more placements during the period under review. (Figure 17)

Out of those 18 cases with three or more moves, three had six or seven placements during the review period (seven placements was the greatest number of moves for any child in reviewed cases).

Figure 18

In looking at the number of placements by age group, **56%** of the children in the age group 0-5 had only one placement during the period under review, **69%** of the children in the age group 6-12 had only one placement during the period under review, and **39%** of the children in the age group 13-18 had only one placement during the period under review. Of the three age groups, teen-aged children experienced the least stability of placement. (Figure 18)

**Item 5- Permanency goal for child** focused on the permanency goal for children in foster care: appropriateness of the identified permanency goal, timely establishment of the permanency goal, and in cases where the child has been in care 15 out of the last 22 months, there was a Termination of Parental Rights (TPR) petition filed or there was a compelling reason documented for not filing TPR.

Figure 19

Item 5 had a **56%** strength rating for the 86 applicable cases. Of these cases, **81%** had permanency goals established in a timely manner, **76%** of the permanency goals were appropriate based on the child’s needs and case circumstances, and the agency either filed or joined a TPR petition in a timely manner or documented an exception to filing TPR in **40%** of the 30 applicable cases. (Figure 19)

When Item 5 was rated as an Area Needing Improvement, it was most often because the TPR was not filed timely and there was no evident compelling reason not to do so. In some cases, reunification remained the permanency plan although it was no longer appropriate. Similarly, there were cases where the identified permanency plan was not appropriate to the circumstances of the case.

Other issues less frequently identified included permanency plans not established timely and lack of consistency between the court-ordered permanency plan, the permanency plan identified in SHINES, and the permanency plan the staff reported as the current permanency plan for the case.

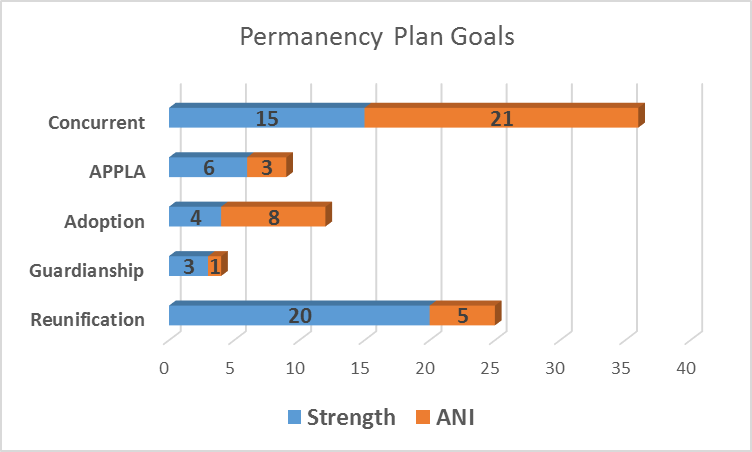


Figure 20

concurrent permanency plan (reunification concurrent with another permanency plan), was the most frequently identified permanency plan in the applicable cases reviewed (36 of the 86 applicable cases), then reunification (25 of the 86 applicable cases), adoption (12 of the 86 applicable cases), APPLA (nine of the 86 applicable cases) and lastly Guardianship (four cases of the 86 applicable cases) (Figure 20).

There were four cases of the 90 foster care cases not applicable to Item 5 because the children were not in care long enough for a plan to have been established.

Figure 21

Both Region 6 and Region 7 achieved a 100% rating for Item 5 (Figure 21***).*** With the next highest rated Regions being 14 and 8 rating at 75% for Item 5. The applicable case in Region 2 rated at **0%**.

**Item 6- Achieving reunification, guardianship, adoption or other planned permanent living arrangements**  purpose was to assess whether concerted efforts were made, or are being made, during the period under review to achieve reunification, guardianship, adoption, or APPLA. If concurrent goals are in place, both goals were assessed.

To meet ASFA, the following time frames must be achieved-- Reunification by 12 months, Guardianship by 18 months and Adoption by 24 months. If the child had been in foster care for more than the identified time frame for a particular goal, and the goal had not been achieved, Item 6 was most likely rated as an Area Needing Improvement. Of the 90 applicable cases, Item 6 was substantially achieved at **40%.**

Item 6 was most often an Area Needing Improvement when the ASFA timeframes were not met. Identified issues included delays or failure to provide needed services to achieve permanency timely, insufficient contacts with parents and/or service providers to facilitate and support progress on reunification cases, failure to file for TPR timely resulting in adoption not being achieved within 24 months, and having concurrent permanency plans with only one plan being worked.

Figure 22

Concerted efforts to achieve the permanency plan rated highest in cases with guardianship identified as either the only plan or as a concurrent plan; **67%** of those cases were rated as a strength (six of nine applicable cases). Concerted efforts to place a child with a goal of APPLA in a living arrangement considered permanent until discharge from foster care were made in **50%** of the reviewed applicable cases (five of 10 cases with the permanency plan of APPLA as either the only identified plan or as a concurrent plan).

The agency made concerted efforts to achieve the goal of reunification in **40%** of applicable cases (25 of 62 cases with an identified goal of reunification either as the only plan or as a concurrent plan). When adoption was the identified permanency plan, only **20%** (nine of 44 applicable cases with adoption as the only plan or a concurrent plan) revealed concerted efforts to achieve the permanency plan. (Figure 22)

Figure 23

None of the regions received high ratings for Item 6 (Figure 23). Region 5 rated highest at **71%**, while none of the remaining Regions rated above **50%.**  Region 7 and 8 rated the lowest at **0%**.

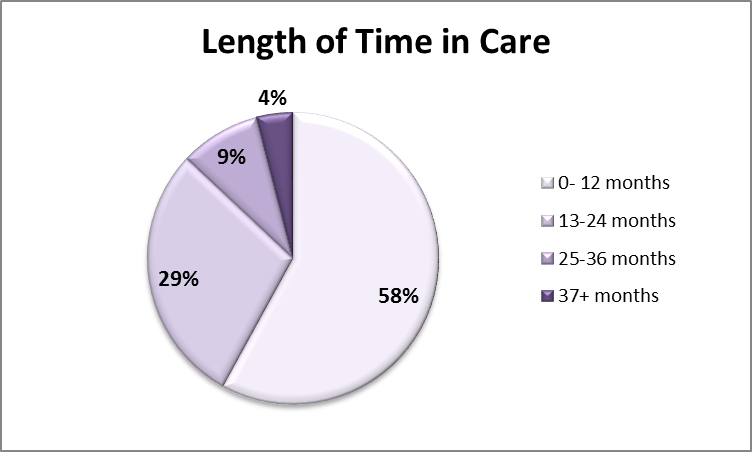
****

Figure 24

The length of time the children had been in foster care ranged from one month to 53 months. Twelve of the reviewed children (**4%**) had been in care 37 months or longer. (Figure 24)

Permanency Outcome 2- The continuity of family relationships and connections is preserved for children

**Permanency Outcome 2** was measured by looking at efforts to ensure siblings are placed together (Item 7); efforts to ensure adequate visitation between children in care and their parents and siblings who are also in care (Item 8); efforts to preserve the child’s connections to his or her neighborhood, community, extended family, Tribe, school and friends (Item 9); placement with relatives (Item 10); and efforts to promote, support or maintain a positive relationship between the child in care and his or her mother and father (Item 11). This Outcome solely focuses on relationships and connections the child(ren) had prior to entering foster care.

Figure 25

Overall the state rated at **33%** substantially achieved for Permanency Outcome 2. (Figure 25). This item only showed minimal improvement from the CFSR review rating of **32%**.

The state did not achieve substantial conformity for Permanency Outcome 2, nor in any of the five items comprising this Outcome in the six month reporting period (January 2016 through June 2016). The ratings were lowest in item 11(relationship of child in care with parents) at **36%** and item 9(persevering connections) at **41%**.

Reasons for the decrease in ratings included the agency’s failure to engage the parents in visiting with their children, not inquiring about the child’s important connections, and not encouraging the parents to participate in any and all of the child/children’s medical or school meetings or other extracurricular activities outside of visitation.

**Permanency Outcome 2- Region Comparison**

Figure 26

Region 2 (**100%**) and Region 10 (**71%**) rated the highest for this outcome. The other 12 regions rated at **50%** or below. (Figure 26)

**Item 7- Placement with siblings** focused on whether concerted efforts were made during the period under review to ensure siblings in foster care were placed together unless a separation was necessary to meet the needs of one sibling. Overall, most regions were not performing well in this area.

Identified issues most frequently causing an Area Needing Improvement rating included:

* Failure to clearly document the reasons for sibling separation when it was not evident the separation was necessary to meet the needs of a sibling
* Foster homes were not able to take large sibling groups
* When children were initially separated for a valid reason, the agency did not re-evaluate the need for continuing separation through the life of the case

Of the 55 applicable cases, this item had a **71%** strength rating. In **36%** of these cases, the child was placed with all siblings who were also in foster care. In 19 of 35 applicable cases **(54%)** where siblings had been separated, a valid reason existed for the separation.

Figure 27

Regions 8, 10 and 11 rated at **100%** strength for Item 7, while Regions 7 achieved **0%** strength. Region 2 did not have an applicable case to this item. (Figure 27)

Item 8- Visiting with parents and siblings in foster care assessed whether concerted efforts were made during the period under review to ensure visitation between a child in foster care and the mother, father and siblings were sufficient (frequency and quality) to promote continuity in the child’s relationship with family members. Based on federal guidance, the agency should consider the needs of the child to support frequency of the needed visitation between children and parents and/or siblings. For example, a younger or special needs child may require weekly or daily visits to meet their need for frequency of visitation. In addition, special attention should be paid to the quality of visitation (i.e. location, family interaction etc.).

Figure 28

Regions 2 and 6 rated at 100% strength, while Regions 7, 8 and 11 rated at 0% for the applicable cases for this item. (Figure 28)

Lack of substantial conformity in this item was reflected in both the frequency and the quality of the visits with mothers, fathers and siblings. One major contributing factor was the lack of a set visitation plan with families to ensure that appropriate visitation between parents and siblings occurred regularly. Lack of contacts with the parents, both mother and father, also impact this item.

It was also noted in cases where one or both parents were incarcerated, the agency did not make concerted efforts to ensure visits or other type of contact (letters, phone calls, etc.) were occurring, when deemed appropriate. There were a few cases where the agency did not make efforts to locate the parents, in order to provide visits.

Siblings who were not placed together, did not have regular visits or contacts, also negatively impacted their ability to have needed visitations. Again, the agency was not making any concerted efforts to arrange visits or utilize other forms of contact between siblings.

Based on the 72 applicable cases, Item 8 rated as a strength in **43%** of the cases reviewed.

Figure 29

There was only a slight difference in the frequency of visits with mothers, fathers, and siblings. The quality of the visits rated slightly higher for the mothers and fathers, but rated lower for the siblings. It appeared the agency had service providers in place that at times monitored and clearly documented the quality of visits with the parents. However there was a lack of quality documented contacts between siblings, as well as missing sibling visits. (Figure 29)

**Item 9**- **Preserving Connections** determined whether concerted efforts were made during the period under review to maintain the child’s connection to his or her neighborhood, community, faith, extended family, Tribe, school and friends.

During the review period, this item rated as a strength in **41%** of the **90** applicable cases. The factor that negatively impacted this item was the lack of discussion with the child(ren) and/or parents to identify important connections such as school, friends, former caretakers and/or extended family members. In some instances, important connections may have been identified but there were no efforts to maintain or support these connections for the child.

Figure 30

Region 2 **(100%)** and Region 4 **(86%)** rated the highest for Item 9, while Regions 7, 8, 9 and 12 rated the lowest at **0%**. (Figure 30)

**Item 10- Relative Placement** considered whether concerted efforts were made to place the child(ren) with relatives (maternal or paternal) when appropriate.

Of the **87** applicable cases, only **44%** had a strength rating. At the time of the review, only **20%** ofthe children in the applicable cases were placed in the home of a relative, with **100%** of these placements being stable.

The agency often did not make concerted efforts to locate, identify or evaluate both maternal and paternal relatives. In some case the relatives were known, but the agency never contacted them or completed a relative assessment. In other cases, the agency did not even inquire about the possibility of relative placements and/or did not follow up on the possibility of relative placements after an initial discussion of this with families.

The agency also failed to consistently talk with children on an ongoing basis to inquire about whom they see as their relatives, and who they would like to be placed with. The search for relatives did not continue throughout the life of the case to ensure all possible maternal and/or paternal relatives had been identified and considered as a placement possibility.

It was noted during the review that there appeared to be more efforts to search for maternal relatives than paternal relatives. The lack of paternal relatives being contacted could also be attributed to the lack of efforts to locate absent fathers. (Figure 31)

Figure 31

Figure 32

The highest performing regions for Item 10 were Region 7 at **100%** and Region 10 at **86%** strengths. Region 12 rated at **17%** strengths, which was the lowest. (Figure 32)

**Item 11-Relationship of child in care with parents** focused on concerted efforts during the period under review to promote, support and/or maintain positive relationships between the child in foster care and his or her mother and father or other primary caregiver(s) from whom the child was removed (through activities other than just arranging visitation).

Of the **66** applicable cases, Item 11 rated at a **36%** strength. Concerted efforts were made to promote, support and otherwise maintain a positive nurturing relationship between the child in foster care and their mother in **48%** of the 66 applicable cases, and with their father in **32%** of the 37 applicable cases.

This item was rated as an Area Needing Improvement due to the agency not making efforts to notify the parents of medical appointments, school activities, involve them in the child’s therapy, or invite them to other activities their child(ren) were involved in (such as sports, plays, church activities, etc.).

Figure 33

Regions 7 and 8 rated at **0%** strengths for Item 11, while Region 2 rated at **100%** and Region 10 rated at **80%**. (Figure 33)

Interviews sometimes pointed to the agency expecting the foster parent to communicate this information to the biological parents, which could be appropriate. However, the foster parents were more likely to notify the parents after the fact that the appointments had taken place rather than invite the parent to attend with them. It was also noted that the agency was not informing or encouraging the parents at time of entry into care to continue involvement with their child(ren)’s activities and medical appointments.

## 

## WELL-BEING OUTCOMES

### Well-Being Outcome 1-Families have enhanced capacity to provide for their children’s needs

Well-Being Outcome 1 assessed services provided to children, parents and foster parents, engagement of children and families in the case planning process, and the frequency and quality of contacts with children and their parents.

Figure 34

The state’s overall rating for this Outcome was **23%** substantially achieved. The state partially achieved in **52%** of cases and did not achieve in **25%** of cases reviewed. (Figure 34). In comparison to the CFSR review findings, this outcome decreased from **26%** substantially achieved.

Figure 35

Individual region ratings varied across the state with Region 6 rating highest at **57%** substantially achieved, while the lowest ratings (**0%** achieved) occurred in Regions 7 and 8 for Outcome Well-Being 1. (Figure 35)

Figure 36

For Well-Being Outcome 1, performance ratings were significantly higher in Family Support cases (**43**% substantially achieved) than Permanency cases (**20%** substantially achieved) or Family Preservation cases (**13%** substantially achieved). (Figure 36)

As noted during the previous CFSR review, insufficient contact with case participants (parents, children, foster parents and relevant collaterals) was a primary issue identified as negatively impacting Outcome Well-Being 1.

In some cases, there were multiple case managers assigned during the period under review, and months when there was no evidence of contact with principals in the case. There was also a lack of supervisory oversight, with some cases also having multiple supervisors during the period under review.

It was evident that supervisors were reviewing case documentation and previous staffings in only **29%** of cases reviewed. Supervisors’ directives were sufficient to address case specific concerns and facilitate progress in only **26%** of cases reviewed.

In some cases, there were gaps in documentation and no one available for interviews who had knowledge of case activity during the undocumented periods. Reviewers were unable to identify what occurred or determine the quality of any case activity which may have occurred during those gaps. Consequently, applicable items were rated as needing improvement. The resulting inconsistency often led to loss of valuable case information, contacts which were not meaningful, delays in providing needed services, and stalled cases. Only **38%** of cases reviewed had no gaps identified in comparing documentation and information obtained in interviews.

**Item 12- Needs and services to children, parents and foster parents**

The purpose of assessment for Item 12 is to determine whether, during the period under review, the agency (1) made concerted efforts to assess the needs of children, parents and foster parents (both initial, if the child entered care or the case was opened during the period under review, and on an ongoing basis) to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency’s involvement with the family, and (2) provided the appropriate services.

This item is applicable in most cases, with the exception in Family Support cases where reviewers determined that a comprehensive assessment of risk and safety was conducted and no safety or risk concerns were identified. In those cases, Item 12 (and Item 13) would not be applicable. Based on this criterion, there were 14 Family Support cases which were not applicable for Item 12 (and Item 13).

Figure 37

Overall, the state substantially achieved at **19%** for Item 12. Region 6 was the highest performing region, substantially achieving in **40%** of cases reviewed. Regions 2, 7, 8, and 14 achieved in **0%** of cases reviewed for this item. (Figure 37)

Figure 38

Family Support cases rated higher for Item 12 at **25%** substantially achieved than either Family Preservation cases (**13%** substantially achieved) or Permanency cases (**20%** substantially achieved). (Figure 38)

Figure 39

Item 12 is broken down into three sub-items: **12 A --** the assessment of needs and provision of services to meet identified needs for children; **12 B** – the assessment of needs and provision of services to meet identified needs for parents; and **12 C** – the assessment of needs and provision of services to meet identified needs for foster parents.

Ratings for this item reflect the agency’s level of achievement in conducting initial and ongoing comprehensive assessment of needs as well as provision of appropriate services in a timely manner to meet identified needs. The agency substantially achieved in **54%** of cases reviewed for assessment and service provision for children and foster parents. This is significantly higher than assessment and service provision for parents which rated at only **18%** overall. (Figure 39)

One issue negatively impacting Item 12 included formal assessments that were needed but not provided, including psychological evaluations, CCFAs, DV assessments, substance abuse assessments, psychiatric evaluations, and parental fitness evaluations for parents as well as developmental evaluations and trauma assessments for children. In some instances, the quality of formal assessments (particularly CCFAs and trauma assessments) that were completed was inadequate as those assessments were not comprehensive, lacked critical information and/or appropriate recommendations. In addition, informal assessments of needs were not adequate in cases that were lacking quality contacts with families, foster parents, and service providers.

In some cases, needs were clearly identified and services to meet the needs were initiated, but there was insufficient ongoing contact with the family and/or provider to assess whether the service was meeting the identified need or to monitor participation and progress. For example, the frequency of collateral contacts was sufficient in only **36%** of cases reviewed, thus supporting the lack of needed contact with service providers for ongoing assessment of families’ needs. In other cases, needs were appropriately identified but there was a significant delay in initiating services.

Figure 40

Needs and services for children considered in Item 12 A included those related to social competencies, attachment and caregiver relationships, social relationships and connections, social skills, self-esteem, and coping skills.

If the case was a foster care case and the child was an adolescent, the child’s needs for independent living services were also considered. If the case was Family Preservation and a child was placed with a safety resource, the needs and identified services to assist the safety resource in meeting the needs of the child were included in Item 12 A.

The agency adequately assessed the needs of children in **70%** of cases but only provided the needed services in **39%** of cases in which service needs were identified, with an overall rating of **54%** substantially achieved. (Figure 40)

Services needed for children but not provided included Independent Living services, services such as mentoring or extracurricular activities to address children’s poor social skills and self-esteem issues, family therapy, and services to assist safety resources in meeting the needs of the child(ren).

Figure 41

Assessment of a mother’s and father’s needs refers to a determination of what the mother and/or father needed to provide appropriate care and supervision and to ensure the well-being of his/her children. Appropriate assessments for mothers were completed in **47%** of the applicable cases and for fathers in **30%** of the applicable cases. Appropriate services were those that enhanced the mother’s or father’s ability to provide care and supervision and meet the well-being of his or her child(ren). Appropriate services were provided to mothers in **27%** of the applicable cases and to fathers in **18%** of the applicable cases. (Figure 41)

With regard to parents, infrequent contact negatively impacted adequate assessment of needs and engagement with parents. This was noted for both mothers and fathers, and often there was no evidence of diligent efforts to locate or contact out of home or absent parents. Services needed for parents but not provided included family therapy, mental health treatment, substance abuse treatment, DV counseling, etc. In addition, if there was inadequate assessment of needs, then service needs would be considered unknown, thus negatively impacting ratings regarding service provision to parents.

Figure 42

Assessment of foster parents’ needs and provision of services to meet their needs rated **54%** achieved overall. Needs were adequately assessed in **68%** of cases reviewed, and needed services were provided in **51%** of cases. (Figure 42)

Services needed but not provided to foster parents/relative caregivers to children in care most often included childcare assistance and Enhanced Relative Rate (ERR)/reimbursements for financial expenses related to care of the child. In some cases, there had been no discussion of available resources; and in others, there had been discussion but no follow-through to initiate services. Another identified concern was failure to provide adequate assessment or services to support foster parents/relative caregivers and enhance their ability to meet the needs of children with notable behavioral issues.

**Item 13- Child and Family Involvement in Case Planning**

Ratings for this item are based on whether there were concerted efforts made to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis. The state achieved a strength rating in **47%** of the cases reviewed, a slight increase from **42%** during CFSR.

In cases which rated as a strength for this Item, reviewers identified positive family engagement in the case planning process including Family Team Meetings (FTM) conducted with the participation of children and parents, ongoing discussion with parents and children related to identification of family strengths and needs, and monitoring the participation and progress towards completing case plan goals.

Figure 43

The state substantially achieved in **47%** of cases reviewed for this item. Region 3 rated the highest at **69%** substantially achieved for Item 13, while Region 7 rated lowest at **0%** substantially achieved for this item. (Figure 43).

Figure 44

For Item 13, Permanency cases had the highest strength ratings at **49%** (slight increase from 48% during the CFSR), while Family Support cases rated at **40%** and Family Preservation cases rated at **44%** (each increased from 30% during CFSR). (Figure 44)

Figure 45

The agency made concerted efforts to actively involve the child(ren) in the case planning process in **66%** (increase from 58% during CFSR) of the applicable cases, mothers in **59%** (increase from 46% during CFSR) of the applicable cases and fathers in **36%** (decrease from 39% during CFSR) of the applicable cases. (Figure 45)

Insufficient contact with parents and children (in both frequency and quality) was most often cited as an underlying issue resulting in the failure to include parents and children in the case planning process. In some cases parents reported that they did not know what their case plan goals were (some cases did not have a case plan developed despite being open for many months), particularly when staff turnover or changes resulted in multiple case managers and supervisors being assigned to a case during the period under review. Case plans were not always current and/or approved, and some case plans were not individualized for the family’s needs.

**Item 14- Caseworker Visits with Child**

This item focuses on whether the frequency and quality of visits between case workers and children were sufficient to ensure safety, permanency and well-being.

Figure 46

The state’s overall rating for this Item was **68%** (increase from 59% during CFSR). All 150 cases were applicable to Item 14. Regions 2, 6, and 7 achieved substantial conformity for this item at **100%**, and ratings across the regions were generally higher for this item than other items for children within Well-Being Outcome 1. (Figure 46)

Figure 47

Permanency cases rated at **71%** strength for this item. While Family Support and Family Preservation cases rated considerably lower at **63%**, this was still a significant increase from **37%** during CFSR. (Figure 47)

For cases rated as a strength, contacts with children included private conversations and interactions with children; discussions relevant to ongoing assessment, monitoring and case planning; and observations of the home environment, household members interactions with each other, and developmental levels/needs (particularly for younger children or children with developmental delays).

Issues negatively impacting this item included multiple months of missed contacts, failure to observe children in their living environments, and contacts that included little or no meaningful engagement or discussion relevant to reasons for agency involvement, assessment, and case planning with children during visits.

Figure 48

The typical pattern of visits between the case manager and child(ren) was sufficient in **77%** of the cases, with the quality of these visits being sufficient in **72%** of the cases reviewed. (Figure 48)

**Item 15- Caseworker visits with parents**

This item is focused on whether the frequency and quality of visits between caseworkers and the parents of the children were sufficient to ensure the safety, permanency and well-being of the children and promote achievement of case plan goals.

Figure 49

The state achieved a **40%** strength rating for this item. Region 6 was the highest performing region at **71%**. Region 12 was the lowest performing region at **18%**. (Figure 49)

Figure 50

Permanency cases rated the lowest with a **33%** strength rating, while Family Preservation cases rated at **43%**. Family Support cases rated the highest at **53%**. (Figure 51)

Figure 51

The typical pattern of visits between the case manager and mother was sufficient in **63%** of the cases, with the quality of these visits being sufficient in **58%** of the cases reviewed. The typical pattern of visits between the case manager and father was sufficient in **49%** of the cases, with the quality of these visits being sufficient in **53%** of the cases reviewed. (Figure 51)

Issues impacting this item included multiple months during the period under review when there were missed contacts, lack of contact with parents in their home to assess living environment when reunification was the permanency goal, and no evidence of concerted efforts to maintain contact with parents. Often there were no efforts made to contact and/or engage out of home/absent parents. Quality was often lacking, with a lack of relevant discussion to address new or previously identified issues, to ensure services were in place, or to monitor progress and case planning. In some instances, approved contact standards were not appropriate for case circumstances (i.e. letters to locally incarcerated parents, phone calls to parents with permanency goal of reunification, etc.), and though contact standards were met they were insufficient to assess and address concerns.

### Well-Being Outcome 2- Children receive appropriate services to meet their educational needs

Well-Being Outcome 2 evaluates whether, during the period under review, the agency made concerted efforts to assess children’s educational needs initially and ongoing, and whether the identified needs were appropriately addressed in case planning and case management activities. There is only one item associated with this outcome, **Item 16- Educational needs of the child.**

Figure 52

For the period under review, the state overall substantially achieved this Outcome in **53%** of the 97 applicable cases. (Figure 52). This was a decrease from CFSR findings which rated Well-Being 2 at **52%**.

Figure 53

In comparing ratings for Item 16 across programs, Permanency cases rated slightly higher than the state overall at **60%** of applicable cases rating as a strength. Of the Family Preservation cases reviewed, the agency rated at **29%** of applicable cases rating as a strength. Five Family Support cases were applicable for item 16, and overall rated at only **20%**. (Figure 53)

**Item 16- Region Comparison**

Figure 54

Regions varied widely in achievement of Item 16. Seven out of 14 Regions rated at **50%** or less for item 16. Region 2 rated at **100%** and Region 3 rated at **90%** of applicable cases as a strength during the period under review. Regions 6 and 10 while not meeting the standard, rated at **75%** for this item. (Figure 54)

Regions that performed better in this area demonstrated thorough ongoing assessment of children’s educational needs as well as timely provision of services to meet the identified needs.

The most common factor negatively affecting ratings for this outcome was the lack of contact with the school/educational providers. This affected cases across all program areas. Interviews and documentation indicate that when educational needs were identified during the period under review, the agency failed to follow through with issues concerning Individualized Education Plan (IEP)/special education, poor or failing grades, behaviors resulting in suspensions, availability of tutoring, as well as attendance and tardies. Often children would be interviewed at school, with the agency failing to have contact with school personnel for the purpose of a relevant collateral contact.

Overall, the agency did well in discussing educational issues with the child, parents and foster parents/placement providers. Documentation and case interviews during the CFSR indicated the majority of information regarding the child’s school performance and educational needs were gathered from the caretaker, without any independent assessment or confirmation. In many Permanency cases, the agency relied solely on the foster parent or Child Care Institution (CCI) to assess the child’s academic needs, to provide services and to oversee progress. In several cases, case managers were unable to state whether a foster child had an Individualized Education Plan (IEP), what it was for, what services a child was receiving and if the child was making any progress with provided services.

Another issue impacting item 16 was the agency’s failure to complete follow through with an Educational Programming, Assessment and Consultation (EPAC) referral or to ensure the EPAC action plan was being addressed. If an EPAC referral and action plan had been completed prior to the current case manager, the case manager would often not know if it had been completed or was unfamiliar with the action plan or its location in the case file. Other issues were the agency’s failure to obtain school records, to include current grades, IEP’s, and attendance and behaviors during the period under review.

### Well-Being Outcome 3-Children receive adequate services to meet their physical and mental health needs

This outcome focused on whether, during the period under review, the agency assessed and addressed the physical, dental and mental health needs of children.

Figure 55

The state overall achieved substantial conformity in only **31%** of 135 applicable cases. (Figure 55). This is a slight increase from the CFSR findings where this outcome rated at **25%**.

Figure 56

In keeping with the overall state rating of **31%** for Well-Being Outcome 3, four of the Regions rated at or below **20%** for the overall Outcome. Of the remaining ten Regions, nine rated at or below **50%** with only Region 6 rating higher at **57%.** (Figure 56)

Figure 57

In comparing ratings across program areas in Well-Being Outcome 3, Family Support cases rated highest at **43%** substantially achieved. Permanency cases rated at **30%** and Family Preservation cases rated at **25%**. In cases where Item 3 was not applicable, it was due to the outcome not being relevant to the reasons for agency involvement, and/or there were no issues affecting physical or mental health of the children reported. A total of 135 applicable cases were reviewed. (Figure 57)

**Item 17-Physical health of the child** evaluated the agency’s assessment of and provision of services to meet a child’s physical and dental health needs.

Figure 58

Assessment and service provision of physical/dental health was achieved overall in **53%** of the 116 applicable cases reviewed. Both Permanency and Family Support cases rated higher than Family Preservation, which rated at **43%** as a strength for item 17. (Figure 58)

Figure 59

Regions individually fared somewhat better in achieving item 17, with half of the regions receiving a strength rating for at least **50%** of applicable cases. Higher performing regions reflected adequate assessment of children’s medical needs as well as follow up to ensure that services were provided to meet identified needs. (Figure 59)

One particular issue which led to lower ratings was lack of contact with medical and dental providers, either to assess the child’s physical/dental needs or to ensure appropriate treatment for identified needs. These included medical and dental issues, included Bell’s palsy, prenatal drug exposure, diabetes, malnutrition, asthma, and decayed teeth.

All Permanency cases were applicable to be rated for Item 17 because the agency had a responsibility to ensure that children in the Division’s care receive adequate treatment to meet their medical and dental needs. Of the applicable cases, documentation and case interviews did not support even cursory contact with a foster child’s medical or dental provider, or contact with specialists treating children with special needs (ENT Specialist, Orthodontists, Allergists, Pulmonologists, etc.).

Documentation and case interviews during the CFSR indicated the majority of information regarding the child’s physical and dental needs were gathered from the caretaker, without any independent assessment or confirmation. In many Permanency cases, the agency relied solely on the foster parent or Child Care Institution (CCI) to assess the child’s needs, provide services and oversee progress.

Another significant issue with applicable cases, was insufficient agency oversight of medication prescribed for physical health issues. Appropriate oversight would include observation of the child’s medication and contact with the prescribing physician to ensure appropriate administration and that the medication was addressing the child’s identified health need.

However, in many cases, documentation and case interviews indicated the agency was unaware of the child’s medication received during the period under review or that they were aware that a type of medication was prescribed but did not know the prescription name or dosage, etc. Many case files were lacking even basic medical records, and the health/medication log in SHINES was underutilized and not kept up to date.

It was noted that the majority of applicable cases had Children’s 1st referrals made during the period under review (PUR). However, there was not always follow up with regard to the Babies Can’t Wait (BCW) assessment, which was sometimes lacking due to a child’s repeated placement moves with the referral not following the child. When a child met criteria for BCW services, the agency did not follow through with contacting the assigned therapist for the identified services of physical, speech, occupational and feeding therapy.

Overall, the state did a better job in assessing the health needs of children rather than ensuring that adequate services were provided in response to the identified needs. When services were provided they included the following- follow up on specific allergy sensitivities, ensuring prescription glasses were provided, addressing enuresis, diabetes, prenatal drug exposure, and circumcision problems.

**Item 18-Mental/Behavioral Health of the child** evaluated the agency’s assessment of and provision of services to meet a child’s mental and behavioral health needs.

Figure 60

Assessment and provision of services to meet children’s mental and behavioral needs was achieved overall in only **27%** of applicable cases reviewed. Both Permanency and Family Support cases rated higher than Family Preservation, which only rated at **18%** as a strength for item 18. (Figure 60)

Only Region 2 achieved a rating of **100%** as a strength for applicable cases reviewed for item 18. Three of the regions, Region 8, 9 and 10, rated at **0%** as a strength. (Figure 61)

Figure 61

A lack of consistent contact with mental health providers negatively impacted cases in all program areas. Documentation and case interviews during the CFSR indicated the majority of information regarding the child’s mental health was gathered from the caretaker, without any independent assessment or confirmation. In many Permanency cases, the agency relied solely on the foster parent or Child Care Institution (CCI) to assess the child’s mental health needs, provide services and oversee progress.

Family Preservation cases were rated low overall for Item 18, mainly due to a lack of assessment for identified mental or behavioral health issues. Issues identified in all program areas included the following, - failure to follow up with recommendations to include medication management, assessment for ADHD, and several incidents of failing to assess children for chronic exposure to Intimate Partner Violence.

Documentation and case interviews continue to reflect the agency not consistently complying with the psychotropic medication protocol that has been required since May 1, 2013. The agency has failed to maintain contact with prescribing physicians, document County Director approval for medication, maintain medication logs, and discuss the medication (compliance, side effects, effectiveness in treating symptoms) with foster children and caregivers.

Another significant issue was the lack of timely provision of services. This was often due to the agency failing to make referrals timely when needs were identified, incorrect completion of service authorizations, placement moves impacting a child’s ongoing therapy and reported ongoing issues with Amerigroup with regard to needed trauma assessments, which were often delayed for extended periods of time, which in turn delayed the identification of needed mental health treatment for the children we served.

# V. Areas of Concern/Critical Issues

During the six month review period, **28** cases were brought to the attention of the regions for additional follow up. Twenty cases were identified as an Area of Concern and eight cases were identified as a Critical Issue related to a child’s immediate safety. There were also two cases identified as administrative concerns. Of the **30** total cases requiring attention, seven were from the Family Preservation program, six from the Family Support program, and **17** from the Permanency program.

The following definitions are utilized to identify cases that are Areas of Concerns or Critical Issues:

**Critical Issues**- are defined by situations where a child is in present or impending danger and immediate action should be taken by the agency to ensure the safety of the child, and/or a situation where there has been no contact or risk and safety assessment completed on the child in recent months.

**Agency Liability Critical Issues** -are defined by situations in which the agency has allowed a court order to expire and no longer has legal custody of the child, but the child is still in the physical custody of the agency and the agency is still acting in a legal role for the child. It can also be defined by a child having been placed in an unapproved placement setting (i.e. safety resource, etc.) that has not been appropriately approved or assessed, whether the child is in the legal custody of the agency or not.

**Areas of Concern**- are defined by situations where a child or family is in need of a specific intervention, the case management practice is inadequate, and/or the family situation is deteriorating to the point that if the agency does not intervene appropriately in a timely manner the children could be placed at significant risk or danger.

**Administrative Concerns** are defined by situations where a child is not at risk, but state protocol or procedures have not been followed to the extent that it creates a potential liability for the agency, such as repeated/excessive incorrect coding of contacts that indicates contact with family or child when none was made.

Of most concern during this period were four cases identified that involved allegations of maltreatment in care that were not adequately assessed and addressed. In one case, the agency was aware of the child’s placement in a non- approved RBWO placement with allegations of insect infestation at the facility, multiple runaway attempts by the foster child, and supervision concerns related to the child having access to razors in the placement (child had attempted suicide the previous month with a razor). There were additional concerns related to this child’s mental health and the facility failed to ensure that the child’s needs in this area were being met to include allowing the child’s medication to lapse. The agency was also aware of this concern and had not taken actions to address the concerns prior to the QA review.

An additional case involved two children ages 2 and an infant. The children were not seen in their foster home for approximately five months leading up to the QA review. During this period, the maternal grandmother reported on four different occasions that she had observed bruising on the children’s faces during visitation. The grandmother reported additional concerns related to the children being inadequately dressed for the weather with no blankets, shoes or coats, and in reference to the children always appearing sick. There was not adequate follow-up related to these serious issues of concern prior to the QA review. The only assessment entailed asking the foster parent about a mark on the 2 year old’s forehead to which the foster mother responded that it was a “natural dark spot”. The child was not taken to a medical professional for evaluation to determine the cause of the observed marks.

Two of the identified cases with maltreatment in care came from Region 4. One involved allegations of bizarre discipline by the foster parents to include putting rags in the children’s mouths, pinching the children, and throwing a bar of soap at one of the children causing the child to bleed. Although the children were immediately removed from the home, there was no report made to Centralized Intake Call Center (CICC). The County reported during QA interviews that “concerns of inappropriate discipline” were staffed with the Resource Development Unit who had addressed the concerns with the foster parents. However, there is no documentation on file to support that the concerns were addressed or how they were resolved with the foster parents.

There were prior allegations of inappropriate discipline employed by these same foster parents. A screened out report regarding these allegations indicated that the concerns would be addressed through a corrective action plan as a policy violation; however, there is no documentation to support agency assessment of the reported concerns.

The second case involved an open Investigation related to supervision concerns on a foster home. During this assessment, additional allegations arose regarding the foster mother’s adult son, who was an unreported household member. During a home visit the adult son was observed by a case manager yelling and using profanity possibly in reference to the foster child. The case manager did not conduct an adequate assessment of the situation to determine who the adult son was referring to, but the foster child reported that he was referring to her and that the son had also called her derogatory names. While the initial supervision allegations were unsubstantiated and there was some preliminary assessment of the adult son’s presence in the home, the son was not fully assessed according to policy as a household member nor were the allegations regarding the son’s yelling, profanity, and derogatory comments towards the foster children addressed.

Multiple cases across all program areas were identified due to a lack of thorough and ongoing assessment of parental capacities particularly in regards to mental health, substance abuse, stability, domestic violence, and parenting. Fifteen cases of the total cases across all program areas were identified due to a failure to adequately assess additional household members and caretakers. This includes not completing required safety screenings on all household members, Safety Resource placements, and relative foster home placements as well as assessing the capacity of additional caretakers.

In six of the cases reviewed, there was a significant lapse in contact with families and children with no diligent efforts to locate them. In an additional seven cases, the agency failed to thoroughly assess the safety of all of the children residing in the home. For example, in one case the agency failed to interview or assess two children who had been returned to the custody of the mother even though the mother had unresolved drug issues and had recently tested positive for cocaine (five additional children remained in the agency’s custody).

Three cases were identified related to relative foster caregivers and Safety Resource placements allowing unsupervised contact with maltreators and other unapproved relatives. There was one Family Preservation case and one Placement case in which the children were exposed to subsequent incidents of maltreatment as a result of unsupervised, unapproved contact with biological parents.

Overall, there was a noted lack of comprehensive assessment of all safety concerns, parental/caretaker capacities, as well as a lack of agency effort to provide services to families to meet identified needs which resulted in the Areas of Concern and Critical Issues.

One of the cases in which an Administrative Concern was identified was related to a Placement case and the second concern was identified in a Family Preservation Case. The Administrative Concerns were primarily attributed to inadequate assessments related to caretakers and household members and of new reports of child maltreatment received on open cases. In one case, there were noted concerns related to supervisory oversight. The supervision was inadequate to identify, assess, and address the safety of children in a timely and comprehensive manner.

Upon receipt of an Area of Concern, Critical Issue or Administrative Concern, all Regions provided follow-up documentation to support that concerns had been addressed or that a plan of action was in place to address identified concerns. Region’s responses included completing additional safety screenings on identified household members and caretakers, additional contacts with children and families to assess safety and current living situations, new Safety Plans to address identified concerns, and the implementation of increased service provision for families in an effort to meet their identified needs. In two cases, the Regions indicated the intent to initiate court intervention in the form of Protective Orders as a means to gain family compliance and to provide an additional level of oversight for the families. In one case, a CPS report was made to CICC to address maltreatment in care allegations.

**VI. Stakeholder Feedback**

The input of **220** stakeholders was incorporated from January 2016 through June 2016. Case specific interviews and/or surveys were conducted in counties and at the region level with case managers, supervisors, community partners, including foster parents, service providers, court personnel, attorneys, and school personnel.

**General Information**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| Rate DFCS staff accessibility to your organization (easy to locate, return telephone calls timely, etc) | 26% | 43% | 25% | 6% |
| Rate DFCS effectiveness of partnership with my agency/organization | 36% | 47% | 16% | 1% |
| Rate DFCS staff effectiveness in identifying children at risk and providing emergency services or removal when placement is warranted. | 21% | 57% | 21% | 1% |
| Rate the agency’s effectiveness in providing appropriate services to meet the needs of families and children which they serve both through CPS and Permanency | 21% | 58% | 21% | 0% |
| Rate the agency’s effectiveness in individualizing the needed services to meet specific needs for the families and children which they serve through CPS and Permanency | 20% | 53% | 22% | 5% |
| Rate the services provided by DFCS to ensure children are safe and protected from abuse and neglect | 26% | 62% | 11% | 1% |

**Foster Parents:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| Rate the agency’s effectiveness in notifying you in a timely manner of upcoming court hearings, panel reviews, etc | 11% | 45% | 11% | 33% |
| How would you rate the effectiveness of the agency in allowing your input and opinions during court hearings and case panels to be heard | 31% | 43% | 13% | 13% |
| Rate the agency’s effectiveness in providing services you have requested | 32% | 48% | 0% | 20% |
| Rate the initial foster parent training provided DFCS | 47% | 53% | 0% | 0% |
| Rate ongoing training provided for foster parents by DFCS | 28% | 72% | 0% | 0% |
| How would you rate your overall working relationship with DFCS | 26% | 41% | 19% | 14% |

**Legal Providers/Court Personnel:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| Rate the agency’s achievement of permanency and stability for children in foster care in a timely manner | 7% | 44% | 37% | 12% |
| Rate DFCS staff dress and professionalism in court proceedings | 31% | 51% | 18% | 0% |
| Rate the preparedness of DFCS staff for staffings and providing me with the information needed to make sound legal decisions | 14% | 40% | 36% | 10% |
| Rate DFCS staff knowledge about their cases and their effectiveness as witnesses in court | 21% | 44% | 31% | 4% |
| Rate the appropriateness of Court documents prepared by DFCS staff. (are they well written and provide necessary information) | 23% | 60% | 17% | 0% |
| Rate the Communication and collaboration between DFCS and CASA/GAL staff on mutually assigned cases | 10% | 64% | 24% | 2% |

**Service Providers:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| Rate the DFCS referral information provided to your agency. Are you provided with the information needed to understand the case situation? | 16% | 41% | 29% | 14% |
| DFCS referrals to our program are timely (based on family’s situation and the types of services needed) | 20% | 60% | 18% | 2% |
| Rate the Ongoing follow up by DFCS with your agency to determine whether the services were initiated timely and are effective in meeting the needs of the families and children | 17% | 50% | 25% | 8% |
| Rate DFCS effectiveness in involving your agency in decision making on cases when appropriate | 31% | 46% | 15% | 8% |
| Rate DFCS effectiveness in keeping your agency informed about mutual cases and notifying your agency before case closure or transfer | 21% | 33% | 29% | 17% |

# Case Managers:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| How effective is your county in meeting the needs of the children you serve both in foster care cases and CPS cases? | 14% | 62% | 23% | 1% |
| Rate the availability of services to meet the needs of children and families in your county/region | 12% | 44% | 33% | 11% |
| Rate the effectiveness of initial training received and preparedness for your job responsibilities | 3% | 42% | 38% | 17% |
| Rate the effectiveness of ongoing training for your continued job responsibilities | 11% | 60% | 19% | 10% |
| Rate your overall experience and/or support you have received regarding critical case management decisions | 27% | 50% | 17% | 6% |

# 

# Supervisors:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor |
| How effective is your county in meeting the needs of the children you serve both in foster care cases and CPS cases? | 0% | 67% | 30% | 3% |
| Rate the availability of services to meet the needs of children and families in your county/region | 15% | 33% | 41% | 11% |
| Rate the effectiveness of initial training provided to new case managers | 5% | 44% | 44% | 7% |
| Rate the effectiveness of ongoing training for case managers | 0% | 42% | 50% | 8% |
| Rate your overall experience and/or support you have received regarding critical case management decisions | 26% | 52% | 15% | 7% |

# VII. Continuous Quality Improvement

The overall vision for Continuous Quality Improvement (CQI) is to be the catalyst that enables the Division to become the best child welfare agency in the world. The Division’s Quality Assurance team completed the on-site review portion of the third round of the Child and Families Service Review (CFSR). From this review and with the inclusion of members at all levels of the Division, including external stakeholders, a Performance Improvement Plan (PIP) was developed and submitted to the Administration for Children and Families Children’s Bureau for approval. Over the next three years, implementation of the CFSR PIP will flow through the State and local CQI teams. The CQI Unit has been educating region teams of CFSR findings and preparing teams for meeting the PIP requirements and aligning Quality Improvement Plan (QIP) goals and interventions for improving performance outcomes. The CQI Unit continues the work of improving the stability and functional capacity of region CQI teams through monthly CQI meetings, quarterly Statewide CQI Facilitators’ and C3 Coordinators’ (CQI, CFSR, Child and Family Services Plan-CFSP) meetings and ongoing CQI training. Below is a brief status report on the work and ongoing efforts of CQI within the state:

**Training and Education**

The CQI Unit Specialists received formal training and professional development for developing a strong state CQI system and process as well as for increasing the capacity of region CQI facilitators and team members. To promote continued team growth and development, the CQI unit provided ongoing CQI training throughout the State. Within the past six months, the CQI Unit Specialists conducted CQI and Performance Improvement training in Region 12 to accommodate members in the Southeastern regions of the State and training was conducted with our State Office of Family Independence counterparts. The CQI unit will provide CQI training in the middle Region of the State as of August 2016 with plans to continue in the Northern and Metro Regions within the next 6 to 12 months.

Quarterly Statewide CQI Facilitators’ meetings are conducted with the region CQI team facilitators and C3 Coordinators. This meeting provides opportunities for training and capacity building in areas such as CQI, Performance Improvement, Quality Assurance review process, data collection, QIP development, Program Improvement Plan process, Child and Family Service Plan process, annual reporting, etc.

**Performance Improvement Collaboration**

The CQI and Quality Assurance units have partnered to assist the regions and their CQI teams with identifying and improving practice areas that impact overall performance outcomes. CFSR Specialists have been matched with CQI Specialists and their regions as an additional support. Once a Regional QA review is completed, the CFSR and CQI Specialists, CQI Facilitators/C3 Coordinators and team members meet to review and discuss QA outcomes and to identify performance practices and changes needed to positively impact the work within the region. A Performance Improvement Collaboration (PIC) is then conducted within each region in which State leadership, Region leadership and other staff, Region CQI teams, community stakeholders, etc. are invited to provide feedback and input related to current practice and changes needed for improving overall performance. Once the PIC is completed, Region CQI teams take the information and input provided and continue to apply the CQI and Performance Improvement process for identifying problems and implementing QIP goals and interventions for improving overall performance and meeting PIP requirements. During this six month reporting period, Performance Improvement Collaborations have been conducted in Region 14 and Region 5.

**C3 - (Child and Families Services Review, Child Family Services Plan, Continuous Quality Improvement)**

Regular communication with internal and external stakeholders is continued through the C3 process. This process helps to communicate the goals of Federal and State plans and the purpose and work of CQI for meeting the goals of these plans, as well as provide opportunity for stakeholders to have input and feedback. The C3 Roadshows are conducted each year across the State and region CQI teams are gearing up to begin this process as of August 2016.

# VIII. Appendix

The following charts and tables provide a further breakdown of the CFSR Outcomes and results discussed in this report.

**Outcome Comparisons of 2015 CFSR Review (April 2015-September 2015)**

**to QA Reviews January 2016-June 2016**

**Regional Safety Outcomes Achievement (January 2016-June 2016)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION**  **06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome S1:** | **40%** | **100%** | **71%** | **80%** | **60%** | **100%** | **100%** | **40%** | **50%** | **100%** | **75%** | **37%** | **64%** | **87%** |
| Item 1: | **40%** | **100%** | **71%** | **80%** | **60%** | **100%** | **100%** | **40%** | **50%** | **100%** | **75%** | **37%** | **64%** | **87%** |
| **Outcome S2:** | **56%** | **100%** | **57%** | **27%** | **45%** | **71%** | **67%** | **25%** | **0%** | **70%** | **40%** | **25%** | **43%** | **38%** |
| Item 2: | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **25%** | **100%** | **100%** | **50%** | **71%** | **100%** | **67%** |
| Item 3: | **56%** | **100%** | **57%** | **27%** | **45%** | **71%** | **67%** | **25%** | **0%** | **70%** | **40%** | **25%** | **43%** | **38%** |

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

**Regional Permanency Outcomes Achievement (January-June 2016)**

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION**  **06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome P1:** | **20%** | **0%** | **38%** | **14%** | **29%** | **0%** | **0%** | **0%** | **50%** | **29%** | **14%** | **33%** | **16%** | **25%** |
| Item 4: | **70%** | **100%** | **88%** | **43%** | **57%** | **50%** | **100%** | **50%** | **100%** | **100%** | **86%** | **83%** | **69%** | **58%** |
| Item 5: | **60%** | **0%** | **50%** | **57%** | **71%** | **100%** | **100%** | **75%** | **50%** | **43%** | **33%** | **40%** | **36%** | **75%** |
| Item 6: | **30%** | **50%** | **50%** | **43%** | **71%** | **50%** | **0%** | **0%** | **50%** | **43%** | **43%** | **50%** | **15%** | **50%** |
| **Outcome P2:** | **50%** | **100%** | **38%** | **57%** | **29%** | **25%** | **0%** | **0%** | **50%** | **71%** | **14%** | **17%** | **23%** | **17%** |
| Item 7: | **67%** | **NA** | **86%** | **67%** | **83%** | **50%** | **0%** | **100%** | **NA** | **100%** | **100%** | **67%** | **50%** | **43%** |
| Item 8: | **86%** | **100%** | **50%** | **33%** | **71%** | **100%** | **0%** | **0%** | **50%** | **67%** | **0%** | **20%** | **27%** | **20%** |
| Item 9: | **60%** | **100%** | **50%** | **86%** | **57%** | **75%** | **0%** | **0%** | **0%** | **57%** | **14%** | **0%** | **23%** | **33%** |
| Item 10: | **30%** | **50%** | **63%** | **29%** | **29%** | **25%** | **100%** | **25%** | **50%** | **86%** | **33%** | **17%** | **58%** | **45%** |
| Item 11: | **43%** | **100%** | **20%** | **67%** | **43%** | **75%** | **0%** | **0%** | **50%** | **80%** | **20%** | **20%** | **22%** | **22%** |

**Regional Wellbeing Outcomes Achievement (January 2016-June 2016)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **REGION**  **01** | **REGION 02** | **REGION**  **03** | **REGION 04** | **REGION**  **05** | **REGION 06** | **REGION**  **07** | **REGION 08** | **REGION**  **09** | **REGION 10** | **REGION 11** | **REGION 12** | **REGION 13** | **REGION 14** |
| **Outcome WB1:** | **31%** | **33%** | **43%** | **19%** | **9%** | **57%** | **0%** | **0%** | **33%** | **30%** | **20%** | **25%** | **24%** | **10%** |
| Item 12: | **33%** | **0%** | **38%** | **18%** | **9%** | **40%** | **0%** | **0%** | **33%** | **22%** | **11%** | **25%** | **22%** | **0%** |
| Item 13: | **50%** | **50%** | **69%** | **55%** | **27%** | **60%** | **0%** | **29%** | **33%** | **67%** | **63%** | **33%** | **65%** | **22%** |
| Item 14: | **75%** | **100%** | **71%** | **45%** | **82%** | **100%** | **100%** | **38%** | **33%** | **80%** | **90%** | **42%** | **62%** | **67%** |
| Item 15: | **42%** | **67%** | **58%** | **29%** | **27%** | **71%** | **33%** | **25%** | **33%** | **44%** | **50%** | **18%** | **50%** | **30%** |
| **Outcome WB2:** | **43%** | **100%** | **90%** | **40%** | **38%** | **75%** | **0%** | **14%** | **0%** | **75%** | **67%** | **71%** | **60%** | **42%** |
| Item 16: | **43%** | **100%** | **90%** | **40%** | **38%** | **75%** | **0%** | **14%** | **0%** | **75%** | **67%** | **71%** | **60%** | **42%** |
| **Outcome WB3:** | **47%** | **50%** | **43%** | **9%** | **38%** | **57%** | **33%** | **14%** | **0%** | **22%** | **33%** | **0%** | **31%** | **40%** |
| Item 17: | **93%** | **50%** | **80%** | **33%** | **57%** | **71%** | **0%** | **40%** | **50%** | **75%** | **33%** | **27%** | **43%** | **41%** |
| Item 18: | **27%** | **100%** | **42%** | **18%** | **33%** | **25%** | **50%** | **0%** | **0%** | **0%** | **50%** | **14%** | **36%** | **36%** |

Substantial Conformity for Outcomes: 95% or above; 94%- 80%; Below 80%

Substantial Conformity for Items: 90% or above; 89%- 80%; Below 80%

**District Comparisons January 2016-June 2016**

**North District (Regions 1-5) -55 applicable cases**

**Metro District (Regions 13 and 14) - 42 applicable cases**

**South District (Regions 6-12) – 53 applicable cases**

**Safety 1 and 2**

**Permanency 1**

**Permanency 2**

**Well Being 1**

**Well Being 2 and 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Comparison Chart**  **All Zones All Regions**  **90 Foster Care/ 30 Family Preservation/ 30 Family Support** | | | | |
| **Safety** | | **Statewide**  **Federal**  **CFSR Review**  **2015** | **As of June 30, 2016** |
| **Outcome S1: Children are, first and foremost, protected from abuse and neglect.** | | **66%** | **70%** |
| **Item 1:** | **Timeliness of initiating investigations of reports of child maltreatment (80 cases)** | **66%** | **70%** |
| **Outcome S2: Children are safely maintained in their homes whenever possible and appropriate.** | | **43%** | **45%** |
| **Item 2:** | **Services to family to protect children in home and prevent removal or re-entry into foster care (41 cases)** | **59%** | **78%** |
| **Item 3:** | **Risk assessment and safety management (150 cases)** | **43%** | **45%** |
| **Permanency** | |  |  |
| **Outcome P1: Children have permanency and stability in their living situations.** | | **14%** | **21%** |
| **Item 4:** | **Stability of foster care placement (90 cases)** | **68%** | **71%** |
| **Item 5:** | **Permanency goal for child (86 cases)** | **42%** | **56%** |
| **Item 6:** | **Achieving reunification, guardianship, adoption, or other planned permanent living arrangement (90 cases)** | **27%** | **40%** |
| **Outcome P2: The continuity of family relationships and connections is preserved for children** | | **32%** | **33%** |
| **Item 7:** | **Placement with siblings (55 cases)** | **77%** | **71%** |
| **Item 8:** | **Visiting with parents and siblings in foster care (72 cases)** | **45%** | **43%** |
| **Item 9:** | **Preserving connections (90 cases)** | **39%** | **41%** |
| **Item 10:** | **Relative placement (87 cases)** | **46%** | **44%** |
| **Item 11:** | **Relationship of child in care with parents (66 cases)** | **34%** | **36%** |
| **Well Being** | |  |  |
| **Outcome WB1: Families have enhanced capacity to provide for their children’s needs. (Item 12 must be a strength for the Overall Rating to be Substantially Achieved)** | | **26%** | **23%** |
| **Item 12:** | **Needs and services of child, parents, foster parents (136 cases)** | **26%** | **19%** |
| **Item 13:** | **Child and family involvement in case planning (133 cases)** | **42%** | **47%** |
| **Item 14:** | **Caseworker visits with child (150 cases)** | **59%** | **68%** |
| **Item 15:** | **Caseworker visits with parent(s) (130 cases)** | **31%** | **40%** |
| **Outcome WB2: Children receive appropriate services to meet their educational needs** | | **54%** | **53%** |
| **Item 16:** | **Educational needs of the child (97 cases)** | **54%** | **53%** |
| **Outcome WB3: Children receive adequate services to meet their physical and mental health needs** | | **25%** | **31%** |
| **Item 17:** | **Physical health of the child (116 cases)** | **49%** | **53%** |
| **Item 18:** | **Mental/Behavioral health of the child (99 cases)** | **29%** | **27%** |

**Regional Overall Rating of Strengths**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Region** | **Number of Case Reviewed (All Programs)** | **Total Applicable Items Rated as Strength** | **Total Applicable Items** | **% Achieved Items** |
| **1** | **16** | **106** | **194** | **55%** |
| **2** | **3** | **23** | **32** | **72%** |
| **3** | **14** | **101** | **164** | **62%** |
| **4** | **11** | **57** | **133** | **43%** |
| **5** | **11** | **69** | **139** | **50%** |
| **6** | **7** | **58** | **84** | **69%** |
| **7** | **3** | **13** | **30** | **43%** |
| **8** | **8** | **22** | **92** | **24%** |
| **9** | **3** | **14** | **39** | **36%** |
| **10** | **10** | **79** | **125** | **63%** |
| **11** | **10** | **55** | **116** | **47%** |
| **12** | **12** | **49** | **141** | **35%** |
| **13** | **21** | **105** | **231** | **45%** |
| **14** | **21** | **107** | **250** | **43%** |
| **State Total** | **150** | **858** | **1770** | **48%** |

The above chart presents the number of cases reviewed per region, the total number of items which were applicable per region and the total number of the applicable items which received a strength rating. It was then calculated by dividing the total number of cases which received the rating of strength by the applicable items which could receive a strength rating to determine the percentage of achieved items. Overall, the State was **48%** of applicable items rating as a strength.