MICHIGAN'S CONSOLIDATED CHILD AND FAMILY SERVICES PLAN

2010-2014

ADDENDUM

September 2009

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Key to Location of Information Requested by Children's Bureau

Highlighted areas in the Addendum indicate material that was added to or altered in the original text for clarification purposes.

Final Report: CFSP 2005-2009

1. Describe the State's activities as a result of receiving adoption incentive payments. Over the past 5 years, it appears that the only year Michigan received an adoption incentive award was for FY05; the amount was $192,000. Please discuss this in your final report.

Please see page 84 of CFSP Addendum.

2. Page 59: We require a description of activities that the State has undertaken for children adopted from other countries, including the provision of adoption and post-adoption services (PI page 6). This section is very brief, please include more details as to how state staff are involved with this process such as licensing and IV-E funding to include non-recurring expenses, public awareness, how Michigan monitors the private's work in this area, how you track international adoptions for reporting purposes to include disruptions and children coming into care.

Please see page 84 of CFSP Addendum.

New CFSP 2010-2014

1. Please have your staff review their area for goals, objectives and measures and make sure that they include objectives and measures, as required. In some sections there are goals listed with no objectives or measures. See PI 9-06 page 8.

Please see revised sections, including Case Practice Model (page 8), Prevention of Child Abuse and Neglect: Children's Trust Fund (page 10), CAPTA (page 26), and Chafee Foster Care Independence Program (page 60). Additional information, including measurement, is highlighted in yellow.

Pages 20-28 Measures of Progress, see PI page 8.

2. I did not see measures included. the CFSP must describe the methods to be used in measuring the results, accomplishments and annual progress toward meeting the goals and objectives, especially the outcomes for children, youth, and families. Processes and procedures assuring the production of valid and reliable data and information must be specified. The data and information must be capable of determining whether or not the interim benchmarks and multi-year time table for accomplishing CFSP goals and objectives are being met (45 CFR 1357.15(j)).

Please see revisions to the Case Practice Model on page 8.

Pages 88-104 CAPTA

3. Please outline the activities that the State intends to carry out with its state grant funds pursuant to section 106(b)(2).

Please see CAPTA State Grant, page 26.

4. I see much training discussed in the CAPTA section but could not tell which were specifically being funded with CAPTA dollars. Describe the services and training to be provided under the CAPTA grant, see PI 9-06 page 14.

Please see funding indicators following each service and training description in CAPTA State Grant, beginning on page 26.

Pages 64-75 Training

5. See page 13 of PI and please add information pertaining to the last two bullets:

- Description of estimated total cost.
  Please see addition to Training section on page 21.

- Cost allocation methodology.
  Please see addition to Training section, page 22.

Not found in document-Decision making process:

5. Explain how agencies and organizations were selected for funding to provide family support services and how these agencies are community-based. See page 9 of PI 9-06.

Please see Decision-Making Process on page 25.

Pages 111-119 Health Care Plan

6. See PI 9-06, page 10, Health Care Services Plan last three bullets and add the following:

- Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care.
  Please see "Call to Reform", page 50.

- The oversight of prescription medicines.
  Please see System Oversight of Psychotropic Use, page 57.

- How the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.
  Please see information on the Medical Advisory Panel on page 55.

Please review the Health Care Services section of the PI, pages 10-11.

7. There is much information that is missing such as: Was this plan developed in coordination with the state Medicaid agency, and in consultation with pediatricians & other experts as required: How the health care experts were selected?

Please see information on Health Care Access on page 53 and Medical Advisory Panel on page 55.

8. The state's plan for the oversight of medication, especially psychotropic meds.
Please see information on Psychotropic Medication on page 57.

Pages 120-130 CFCIP

9. Please clearly identify the state agency or agencies that will administer, supervise or oversee the programs and provide a statement that indicates that the State agency will cooperate in national evaluations of the effects of the programs in achieving the purposes of CFCIP.
Please see the first paragraph on page 60.

10. It would be great to include measures which show how many youth vs. tribal youth are eligible and using the grants.
Please see CFCIP section on Coordination with Native American Tribes, beginning on page 67.

11. Does the state keep stats on youth using ETV? It would be useful to see how many tribal youth vs. other youth are eligible and receiving ETV.
Please see CFCIP section on Coordination with Native American Tribes, beginning on page 67.

12. How are youth notified about the ETV program and that they are eligible? Please add how the state oversees this process.
Please see bullet points under ETV on page 61.

14. Description of Program Design and Delivery: Address how the state will design, conduct and/or strengthen programs to achieve the purposes of section 477(a) (1-7) of the Act.
Please see The Chafee Foster Care Independence Program (CFCIP) Program Purposes beginning on page 70.

15. See PI pages 15-18. This section is set up as future goals and it is not clear as to what is currently available.
Please add narrative to include the following bulleted items that gives an overview of your overall program current design. How are workers alerted, if they are alerted, when a youth becomes eligible and are they required to complete any type of independent life skills assessment. Finally make sure we understand MI is taking measures to comply with the items that are covered in the certification.

Serving Youth Across the State: Ensure that all political subdivisions in the State are appropriately served by the program.
Please see Youth Service Delivery Model, page 62.

Determining Eligibility for Benefits and Services: Address how the state will use objective criteria to determine eligibility benefits and services, and for ensuring fair and equitable treatment of benefits recipients.
Please see second paragraph under Description of Program Design and Delivery on page 60.

Serving Youth of Various Ages and States of Achieving Independence: Describe how youth of various ages and at various states of achieving independence are to be served. Describe how the State is serving specific age groups. Identify any State statutory or administrative barriers, which need to be eliminated or amended to allow the State to serve a broader range of eligible youth.
Please see CFCIP Program Purposes on page 70.

Room and Board: States are required to certify that no more that 30 percent of their allotment of Federal funds will be expended for room and board for youth who left foster care because they attained 18 years of age but have not yet attained 21 years of age. The state must have developed a reasonable definition of "room and board" and provide the definition in the CFSP. Also include a description of the approach(es) being used to make room and board available to your ages 18 through 20.
Please see third paragraph on page 60.

Medicaid Coverage: Describe how the state has used, or is coordinating efforts to use, the option to expand Medicaid to provide services to youth ages 18 through 20 years old who have aged out of foster care. If the state does not choose to provide Medicaid to all young people under the age of 21 who were in foster care under the state's responsibility on their eighteenth birthday, the state should describe what "reasonable categories" of children it has chosen to provider Medicaid services to, if any.
Please see page 60.

Education and Training Vouchers program: It is understood that the state contracts this to a private provider; yet please: Describe the State's methods of operating the voucher program efficiently and provide assurance that the State will comply with the specified conditions.
Please see page 61.

Training: Provide information on specific training planned for FY 2010 – 2014 in support of the goals and objectives of the State's CFCIP. This information may be incorporated into the training plan section of the CFSP, and noted as CFCIP training. See page 18 of PI 9-06.
Please see page 72.

Education and Training Vouchers: Provide the number of youth who received ETV awards in FY 2008 and year-to-date for FY 2009. Break out numbers of recipients receiving ongoing vouchers and those receiving new vouchers.
Please see page 61.

16. Timely Home Studies Reporting and Data: 98 –See PI 9-06 page 22, states are asked to provide the frequency with which the state needed the extended 75-day period, the reasons why extensions were needed, extent to which the extended compliance period resolved circumstances and steps state took to resolve need for extensions. I'm not sure what MI is reporting for the 75-day information states are required to report on.

Please see additional information on Interstate Compact on the Placement of Children on page 83.

17. Need Payment limitation: Title IV-B, Subpart 2.

Please see report, included with this Addendum: Family Preservation and Family Support Services Expenditures Not Funded by Title IVB(2), *page 85.*

Case Practice Model

Measures of Progress
The CFSP must describe the methods used in measuring the results, accomplishments and annual progress toward meeting the goals and objectives, especially the outcomes for children, youth and families. Processes and procedures assuring the production of valid and reliable data and information must be specified. The data and information must be capable of determining whether or not the interim benchmarks and multi-year timetable for accomplishing CFSP goals and objectives are being met.

Structured Decision Making
The structured decision making model is integrated into the statewide computer system for CPS and foster care. Private agencies are also required to complete the tools using Microsoft® Word templates. DHS supervisors track the completion of the reports via supervisory reports, which are available in the SWSS computer system. The Purchase of Service Division (now called the Child Welfare Contract Compliance Office) monitors the completion of the templates during their annual reviews. Central office will be tracking the percentage of overdue CPS investigation reports and service plans on an annual basis.

Team Decision Making (TDM)
DHS tracks the completion of team decision-making meetings in a database that is a part of the data warehouse. The TDM facilitator enters the data into the database and for reporting purposes, DHS central office is able to track the completion of the TDMs to children in the SWSS system by matching the child IDs.

As the TDM process is rolled out statewide, DHS will continue to monitor the completion of the eight required types of meetings per the rollout schedule.

Caseload Ratios
Both DHS and private agencies are required to report to DHS field operations the caseload ratios for each supervisor and worker. This reporting is done quarterly and recorded on a spreadsheet. If a portion of their time is split between different functions, each function is reported separately. For example, if a supervisor spends 60 percent of their time supervising foster care caseworkers, 20 percent of their time supervising foster care case aides and 20 percent of their time supervising home-based therapists, they report .6 under the “foster care” hours, and .4 as “other duties”. For caseworkers, the agencies must report the FTE hours spent per category and the numbers of cases by type, e.g., foster care, adoption, licensing, etc.

Coordination with Tribes: Office of Native American Affairs

DHS responses to HHS comments/questions in CFSP 2010-2014 section on Coordination with Tribes:

1) How will you strengthen the Indian Outreach Worker Program and can you discuss how many Indian Outreach Workers (IOW) Michigan has and in what counties, as well as what tribes have access to IOW?
The Native American Affairs Business Plan (currently in the process of publication) enumerates the plan to strengthen the Indian Outreach Services (IOS) program. Current IOS policy (updated 7/1/2009) can be found at: http://www.mfia.state.mi.us/olmweb/ex/ios/ios.pdf. Further, each county with an Indian Outreach Worker (IOW) develops a county plan to provide services. The twelve counties with IOWs are: Baraga, Chippewa, Delta, Gogebic, Isabella, Kent, Luce, Mackinac, Marquette, Menominee, Van Buren and Wayne counties. All tribes may access IOWs regardless of where they are located.

2) Can you include the tribes that are served by Families First of Michigan?
Families First of Michigan provides services in all 83 Michigan counties through DHS contracts with area agencies. Eligibility for Families First services is determined by DHS, and tribal referrals would be brokered through local DHS offices or the DHS Family Preservation program office.

3) In the Data Management Plan, is there a plan to provide ICWA case totals and ICWA data measures electronically to individual tribes?
This goal is set for FY 2012. Although it is planned that the information will be shared with individual tribes, the process for this is currently in development.

4) Is DHS capable of pulling data from SWSS related to Tribal youth eligible for CFCIP and ETV, and tribal youth actually receiving these funds?
Yes, DHS has access to the number of youth eligible for CFCIP and ETV funds. Currently, 39 Tribal youth are eligible. We are currently working on developing the ability to pull data on the number of youth actually receiving the funds.

Prevention of Child Abuse and Neglect: Children's Trust Fund of Michigan

The Children's Trust Fund (CTF) serves as Michigan's source of permanent funding for the statewide prevention of child abuse and neglect. Established by the Michigan Legislature as an autonomous agency by Public Act 250 of 1982, CTF does not receive state general funds for operations. CTF has been designated by Governor Granholm to serve as the state lead agency to receive and administer the federal Community Based Child Abuse Prevention (CBCAP) grant.

The United States Congress mandates that states receiving federal Child Abuse Prevention and Treatment Act funding develop and utilize a minimum of three Citizen Review Panels. In 1999, CTF assumed responsibility for overseeing the Michigan Citizen Review Panel for Prevention (CRPP). CTF is working in conjunction with the DHS to strengthen this role in the coming five years.

CTF hired a new executive director in the summer of 2009. The executive director will be responsible for overall operations of CTF finances, staff and local council activities, developing productive relationships with state legislators, state department personnel and the Board of Directors. He will also be responsible for developing and overseeing fundraising activities. The director will also lead CTF in the development of a strategic plan that is built upon the FY2010-FY2012 strategic plan outlined in the 2009 CTF biennial report. The overarching goals identified in the report are:

1. Raise public awareness of child abuse and neglect prevention, and mandated reporting.
2. Foster improved collaboration with new and existing prevention partners at the local, state and national levels.
3. Advocate needed public policy and best practices that address child abuse and neglect.
4. Implement best practices supported by evidence-based and evidence-informed principles.
5. Develop and implement continuous quality improvement practices.
6. Facilitate educational and professional development with all partners.
7. Improve funding opportunities for CTF prevention initiatives.
8. Ensure efficient and results-based use of prevention dollars.

While many of the goals articulated in this five-year plan will coordinate with the new director's vision, future APSR reports may include new directions based on this change in leadership.

To serve Michigan's families and protect Michigan's children, CTF works with an extensive network of local prevention organizations. CTF provides funding for direct service programs and local child abuse and neglect prevention councils (hereafter referred to as "local councils"). By statute, local councils develop and facilitate

collaborative community prevention programs. Councils also conduct local needs assessments and provide public awareness and other prevention services based on community needs. CTF supports its community based prevention programs through training and technical assistance, evaluation assistance, Child Abuse Prevention Month resources, and other support activities.

CTF is also the administrator and fiduciary for the Zero to Three Secondary Prevention Initiative. Zero to Three is a statewide, research and evidence-based, community collaborative prevention model. Zero to Three programs serve Michigan's most vulnerable populations that have multiple risk factors that can contribute to child abuse and neglect. Zero to Three is funded through blended appropriations from DHS, MDE and DCH. The majority of measurements noted in this five-year plan are related to Zero to Three outcomes, as Zero to Three is the only program in which grantees utilize similar program models (i.e., home visiting) and the same measurement tools to then report on the same outcomes.

Zero to Three: Zero to Three programs are more uniform than CTF direct service programs, and outcomes are categorized by legislative requirements. Zero to Three grantees are required to describe their evaluation process including identified, measurable performance objectives for each time-oriented outcome, how they will be measured, and how they integrate with the Zero to Three Secondary Prevention indicators. Outcomes are measured using three main data collection tools: quarterly data collection forms, the Adult Adolescent Parenting Inventory-Bavolek (AAPI-2), and an analysis of CPS involvement. The Zero to Three Initiative has found these evaluation activities to be highly effective in demonstrating the return on investment and effectiveness of these prevention programs.

Goals for FY 2010-2014:

1. Assist Zero to Three programs in providing home visitation services to at-risk families that foster positive parenting skills, improved parent/child interactions, promote access to needed community services, improve school readiness, increase local capacity to serve families at-risk, and support health family environments that discourage alcohol, tobacco and other drug use.
    a. Objectives:
        i. Maintain and expand levels of service for Zero to Three prevention programs.
            1. **Measurement:** Zero to Three grant allocations.
        ii. Provide training and TA to support Zero to Three grantees.
            1. Evaluation results from biennial Supporting Families conference as well as training and technical assistance provided via contracts with Children's Charter and the Michigan Public Health Institute.
2. Zero to Three grants will demonstrate positive outcomes for program participants.
    a. Objectives:

i. Ninety-five percent of participants will report that they were satisfied with services.
    1. **Measurement:** Individualized (program specific) client satisfaction tool. Aggregate data is compiled at the state level.

ii. Ninety percent of participants will report improved parenting skills.
    1. **Measurement:** Zero to Three Data Collection Form (DCF).

iii. The average number of risk factors will decrease after services are provided.
    1. **Measurement:** AAPI-2 and DCF.

iv. Ninety-five percent of children served and exiting services (after caregivers' full completion of services) will not have a Category I or II CPS disposition at the end of the fiscal year for the year being measured.
    1. **Measurement:** Query of all children (ages birth through three) using the DHS data warehouse for CPS substantiations.

v. Ninety percent of children served are up-to-date with age appropriate immunizations.
    1. **Measurement:** DCF.

CTF Service Description
In FY 2009, CTF local councils were in their second year of a three-year grant cycle. Local council allocations are awarded based on compliance with the CTF designation agreement and tier criteria. Most local councils serve a single county, but several northern Michigan councils serve two or three counties. In addition to developing collaborative community prevention programs, councils provide non-direct service prevention activities based on identified community needs.

By statute, local councils have as their primary purpose the development and facilitation of a collaborative community prevention program. Local councils are also charged with conducting local needs assessments and increasing public awareness, and they provide a wide array of additional services based on specific community needs. Activities include providing information and referrals, implementing public awareness campaigns, distributing prevention information, organizing Child Abuse Prevention (CAP) Month activities, providing prevention leadership on local committees, developing local resource directories and providing educational workshops and in service trainings such as Shaken Baby Syndrome, body safety, parent/child nurturing, and mandated reporting.

Direct service grants fund prevention programs and services to promote strong, nurturing families and to prevent child abuse and neglect. Direct service programs are designed to meet identified needs based on community assessments. They provide services to families who do not have an active CPS case (i.e., CTF does not fund tertiary or crisis intervention programs).

Expanding and strengthening the range of services.
A priority for CTF for the coming five years is to evaluate the most effective ways to implement best practices into our grantees' programs and services. Specific areas that CTF will address are the inclusion of evidence based and evidence informed programs and practices (EBP/EIP), improved evaluation processes among grantees, improved reporting on outcomes, and the increased use of logic models. CTF will provide trainings and technical assistance to help grantees develop and implement programs and processes that align with these priorities. Additional goals are as follows:

Local Councils: The four local council work groups, Standards, Capacity Building, Designation Agreement, and Education, developed an overarching guiding body, the Local Council Work Group, in March of 2008. During the coming five years, CTF plans to continue this work group and to explore ways to implement stronger peer review, possibly via "tier mentoring", regional meetings or site-to-site visits.

CTF will also provide outreach and technical assistance to any councils struggling with evaluation or sustainability issues. Starting with the FY 2010 application renewal process, all councils will be required to submit logic models with their prevention plans. While primary prevention activities (that focus on community-wide education) present challenges for measuring outcomes and behavioral change in individuals, CTF will continue to provide training and technical assistance to help strengthen councils' evaluation and outcome activities. In particular, CTF will support the Tier I and Tier II local councils that often do not have the capacity or staffing of the Tier III councils. CTF will also explore ways to help support program areas such as Safe Sleep and Mandated Reporting, in addition to working with local councils and federal partners to identify evidence-informed primary prevention services, outcomes and evaluation tools.

Goals for FY 2010-2014:

1. Assist local councils in sustainability, capacity building, and best practices efforts.
    a. Objectives:
        i. Councils will move positively along the continuum of evidence-informed programs and practices.
            1. **Measurement:** FY 2013-FY 2015 prevention plans will incorporate stronger logic models, expected outcomes, and measurements.
            2. **Measurement:** FY 2013-FY 2015 prevention plans will include incorporation of a greater number of research- or evidence-based programs and practices than FY 2010-FY 2012 plans.
        ii. CTF will provide logic model and outcomes trainings prior to the new grant renewal period (for FY 2013-2015).
        iii. CTF and local councils will increase their collaborative efforts.

1. **Measurement:** Feedback from the monthly local council work group.
2. **Measurement:** Feedback from the annual satisfaction and needs survey.

iv. Councils will develop stronger partnerships with local initiatives (e.g., Great Start Collaboratives, CTF direct service grantees, etc.).
v. CTF will continue to fund 72 local councils at the current level of funding.
1. **Measurement:** Total grant allocations.
vi. CTF will bring Lenawee County, the only county currently without a prevention council, into the CTF-funded network.

2. Provide leadership for Child Abuse Prevention Month.
   a. Objectives:
      i. CTF and councils will implement a coordinated, statewide CAP Month initiative.
      ii. CTF will provide adequate resources to councils for CAP Month.
      1. **Measurement:** CAP Month survey.
3. Incorporate continuous quality improvement principals through a formal peer review process.
   a. CTF will create a best practices work group in FY 2010 to discuss peer review in local councils and identify viable options for peer review.
   b. CTF will implement a formal peer review process with the new three-year council application in FY 2013.

Direct Service Programs: CTF will refine the criteria and outcome expectations of direct service programs to implement a more outcomes-based system. It is important to note that currently, because of the wide array of program models implemented to meet community needs (e.g., ranging from home visitation to parent support groups to respite care), direct service programs do not use the same measurement tools nor do they report on the same outcomes. Rather, they report on their individual activities and outcomes via quarterly progress reports, which are monitored by a CTF grant monitor. However, in the RFP process, direct service grantees are required to identify how proposed services are designed to promote one or more of the five Community-Based Child Abuse Prevention (CBCAP) protective factors: parental resilience, social connections, concrete support in times of need, nurturing and attachment, and knowledge of parenting/child development.

In addition, direct services proposals submitted must include an evaluation component with measurable outcomes in the form of a Conceptual Framework or Logic Model, as identified in the Mandatory Funding Requirements Section, as well as:

- Clear program goals and objectives.
- Client satisfaction assessment tool.

- Measurable outcomes that may be expressed in numbers or percentages, which are related to the local council's needs assessment in their prevention plan.
- Identifiable performance objectives for each outcome, including how they will be measured.

A major change for new FY 2010 grants will be the required use of the FRIENDS Protective Factors Survey (PFS), a valid and reliable tool developed by the University of Kansas, for any family or parent support programs. Use of the PFS will allow CTF to collect more comprehensive, outcome-based evaluation data from its direct service grantees in the future. After baseline PFS data is compiled, CTF will identify the best way to set outcome measures.

In the APSR for 2009, it was noted that the direct service RFP process underwent significant revisions in FY 2008 to strengthen services and improve outcomes. These changes remain in place for 2010, including:

- The requirement that programs minimally meet the "Emerging Programs and Practices" level as defined by the federal CBCAP Program Assessment Rating Tool (PART) guidelines.
- The inclusion of the five protective factors as identified by FRIENDS, and the requirement that grant applicants state how their proposed service(s) will promote one or more of the protective factors.
- Stronger emphasis on parent involvement and leadership.
- A standard form distributed by CTF to report on parent/client satisfaction. This will help CTF more cohesively evaluate client satisfaction and will ensure that grantees are actively incorporating client feedback into their programs.

Peer Review: Over the coming five years, CTF will develop a formal peer review model for the CBCAP funded direct service and local council programs.

It is important to CTF to engage the grantees in developing a viable peer review model. This ensures that grantees have ownership of the process, view it as a positive vehicle to discuss prevention goals and challenges, share resources, and review their practices and procedures. There are many peer review models being used in different states. During the coming five years, CTF will identify and/or develop a preferred model(s) and then implement that model to assure continuous quality improvement.

MSU Partnership: Under our prior five-year plan, CTF awarded a grant to Michigan State University, entitled Children's Central, to explore multiple aspects of child abuse and neglect prevention. The mission of Children's Central is to broaden the definition of child abuse and neglect, and subsequent prevention activities, to include negative effects of media; effect social change for the more ethical practice of advertising and media targeted to children; work toward the protection of families; and generate recognition of violence by or against children. Children's Central will also be involved in examining social marketing and branding strategies that would be most effective for CTF and CTF grantees, particularly local councils. In addition, CTF is currently working with MSU staff to hold a joint conference in November 2009 (FY 2010) that will feature

the CTF annual training as well as the MSU conference entitled, “Consumer Culture and the Ethical Treatment of Children: Theory, Research, and Fair Practice.”

Goals FY 2010-2011:

1. Provide training, public awareness, and educational resources/activities to support the work of CTF and our prevention partners.
    a. Objectives:
        i. MSU Children’s Central will develop and operate a conference on consumer culture and its effects on children.
            1. **Measurement:** Completion of conference and evaluations from attendees.
        ii. MSU Children’s Central will contribute to the development of a special issue of the Spring 2010 issue of *Journal of Advertising*, devoted to advertising and its possible connection to violence and abuse in children and families.
        iii. MSU advertising faculty will develop and present research studies at national and international conferences with appropriate recognition to CTF.
            1. **Measurement:** Quarterly reports to CTF.
        iv. MSU advertising faculty and students will participate with CTF in the development of a public awareness and/or marketing campaign by the completion of the contract period expiring September 30, 2011.

Parent Leadership: Building on the work of the Parent Leadership in State Government Advisory Board and the CTF Parent Leadership Work Group, CTF will continue to support parent leaders, both directly and through our funded programs. In 2010, CTF will identify ways in which parent leaders can be provided the resources they need to succeed at different leadership levels. For example, based on feedback from the Parent Leadership Work Group, CTF provided reimbursements (for appropriate costs) for parent leaders to attend Prevention Awareness Day in March 2009. In FY 2010, CTF will work to expand parent leaders among our funded programs as well as the activities we directly administer, such as the Citizen Review Panel for Prevention.

Two CTF staff serves on the Advisory Board for Parent Leadership in State Government (PLSG). The board was established in December 2006 to equip parents to be partners at the policy table, and it is funded via an interagency agreement between the DCH, MDE and DHS. At least 51 percent of board members must be parents of children ages 0-18 who have been or are eligible to utilize specialized public services (e.g., disability, social services, special education, early childhood intervention, or mental health). Additional goals of the PLSG in FY 2010 will be to help place parents and caregivers in policymaking bodies so they can influence and have a voice in decision-making.

CTF also initiated a collaborative meeting with the Early Childhood Investment Corporation, Michigan Council on Maternal and Child Health, and a Zero to Three parent leader to discuss parent leadership. This joint meeting took place in September

2008. The group met again in December 2008, after expanding the invitation to other lead agencies, and plans to meet quarterly in FY 2009.

Goals for FY 2010-2014:

1. Strengthen parent leadership in CTF-funded programs.
    a. Objectives:
        i. 2010: CTF will increase the parent leadership line item in the budget from $10,000 in FY 2009 to $20,000 in FY 2010.
        ii. 2010: CTF will explore options for implementing stronger parent leadership, including parent leadership training and/or scholarships for parents to attend developmental leadership opportunities.
            1. **Measurement:** If trainings occur, receive feedback via evaluation from participating parents.
        iii. 2012: CTF will explore implementing the FRIENDS "Parent Leadership Development Self-Assessment" tool with new direct service grantees.

Research, evaluation, management information systems, and/or quality assurance systems that will be updated or implemented in FFY 2010.
Moving toward greater knowledge and utilization of evidence-based and evidence-informed programs and practices (EBP/EIP) and evaluation continues to be a high priority for CTF. CTF is working with grantees to achieve this goal. CTF will continue to provide trainings for and monitoring of quarterly and year-end reporting. CTF has made it a priority to help educate our grantees and other stakeholders about the importance of evaluation and outcome accountability, and to provide training and technical assistance in the process.

Program Evaluation: A major change expected for FY 2010 is the implementation of the Protective Factors Survey (PFS) for new direct service grantees. Another change will be the increasing expectation that local councils set measurable objectives in their prevention plans. As in years past, direct service and local council grantees are required to provide quarterly reports (expenditure, program register, and activity reports) to CTF via EGrAMS. Increased training in program data collection and evaluation has significantly increased the quality of grantees' reporting. Therefore, CTF plans to continue to improve the EGrAMS reporting tool as well as provide a high level of EGrAMS/data collection training and technical assistance to support these evaluation activities.

Goals for FY 2010-2014:

1. Move toward greater implementation of evidence-based and evidence-informed programs and practices.
    a. Objectives:
        i. 2010: CTF will form a Best Practices Work Group to examine EBP/EIP for primary prevention and other local council activities.
        ii. CTF will for a Direct Service Work Group, which will include discussion around EBP/EIP, model fidelity, evaluation, peer review,

and other best practices.
iii. CTF will take the PART EBP/EIP information into account when making direct service grant awards.
iv. CTF will educate grantees and other community partners about PART and EBP/EIP via training and TA opportunities.

2. Move toward greater implementation of outcomes-based evaluation.
    a. Objectives:
        i. 2010: Grantees will receive training from CTF to implement the Protective Factors Survey.
        ii. 2011: Client satisfaction in direct service programs will be assessed in a more comprehensive way, using the standardized CTF client satisfaction form.
        iii. 2011-2014: CTF will create a year-end protective factors report, based on data compiled from grantees utilizing the Protective Factors Survey.
        iv. 2013: CTF will create a year-end report highlighting outcome results from each direct service grant program, using the Washington Council for Children and Families as a model.
3. Meet the federal reporting requirements for Program Assessment Rating Tool (PART).
    a. Objectives:
        i. CTF will provide data on the amount of CBCAP funding used to support EBP/EIP.
        ii. CTF will continue to educate new direct service grantees about EBP/EIP and PART goals and requirements.
            1. Measurement: Training provided on PART at the direct service RFP training session.
            2. Measurement: Training provided, as needed, to direct services grantees to re-evaluate their PART level.
        iii. Minimally, all new direct service grantees will have a logic model and meet the other “emerging” level requirements as defined by CBCAP.
        iv. CTF will determine infrastructure costs associated with supporting evidence-based and evidence-informed programs and practices.

Training

CWTI responses to HHS comments/questions in CFSP 2010-2014 on training issues:

1) Does CWTI track staff training to ensure all staff receives required training?
Yes, CWTI adopted a new learning management system this year and we are creating a database that will include each DHS and private agency caseworker and supervisor. With this database, we will be able to track training requirements for staff, specifically, whether staff has completed required pre-service training before assuming more than a three-case training caseload, required in-service training, and supervisor training within the first three months of the supervisor's hire or promotion.

Through this tracking system, DHS can also track other training and are in the process of adding the ability to register and track training on the Team Decision-Making model (TDM) and training that is offered by DHS program or field operations. Monitoring also occurs for certain types of training by the DHS Child Welfare Contract Compliance Unit (formerly the Purchase of Service), that oversees the child placing agency (CPA) compliance, and the Bureau of Child and Adult Licensing (BCAL) that monitors compliance of certain DHS, CPA, and Child Caring Institutions regarding training for staff and/or foster parents (Licensing rule R 400.12209).

2) Does tribal staff have the option to attend training, and include a paragraph stating it, if so.
Tribal social services caseworkers and supervisors are welcome participants in many of CWTI training events. While the full nine-week pre-service institute (PSI) is not appropriate since it focuses on Michigan law, DHS policy, and SACWIS/SWSS training that is not relevant to tribal staff, CWTI opens many of the PSI modules to tribal participants, including medical issues, forensic interviewing, sexual abuse, mental health, etc. In-service training options are also open to tribal participants as space permits.

3) What are the requirements for in-service training? (add to CFSP)
As required under the DHS Settlement Agreement, child welfare in-service training requirements are as follows:

Children's Protective Services Workers
- 16 hours minimum (FY 2009).
- 24 hours minimum (FY 2010).
- 32 hours minimum (FY 2011).
- 40 hours minimum (FY 2012 and thereafter).

DHS Foster Care and Adoption Workers
- 24 hours minimum (FY 2009).
- 40 hours minimum (FY 2010 and thereafter).

CPA/Private Agency Foster Care and Adoption Workers

- 24 hours minimum (FY 2010).
- 40 hours minimum (FY 2011 and thereafter).

4) Are disabilities or the American with Disabilities Act (ADA) included in CWTI training?

Currently, CWTI discussion regarding disabilities focuses on interviewing or working with children with disabilities (physical, educational, psychiatric) during pre-service training. While the lesson plans do not explicitly cover the ADA, pre-service modules deal with relevant topics including engaging parents "where they are" in terms of needs and functioning, and also specifically discusses awareness of parental challenges in sessions focused on mental health and substance abuse. Familiarity with the online policy and procedures manuals is stressed and sections of the policy manuals for CPS and foster care cover topics such as accommodation of individuals with hearing impairments, educational issues under the IDEA, etc.

5) Add training requirements for foster parent training and add duration of training.

CWTI does not provide direct training to foster and adoptive parents; however, it does provide train-the-trainer training. Foster PRIDE/Adopt PRIDE training is the required training curriculum for pre-placement training. Local offices collaborate with private agencies to provide advanced foster parent training.

All prospective foster and adoptive applicants are required to attend the Foster/Adopt PRIDE (Parents' Resource for Information, Development, and Education) training curriculum, which consists of nine modules totaling 24 hours of instruction. Each foster parent must annually participate in a minimum of 15 hours of approved training.

DHS and private CPAs provide orientation, pre-placement and ongoing training for each prospective/licensed foster parent as referenced in the department's foster parent training plan. Combinations of counties/agencies with similar needs, called foster parent training coalitions may deliver training or the local DHS office may deliver training. DHS staff and/or appropriate combinations of staff and available resources may deliver foster parent training.

CWTI conducts PRIDE "train-the-trainer" in a four-day session. This training targets staffs of both DHS and private CPAs. Normally, these individuals are licensing workers, and are responsible for the training of prospective foster/adoptive and relative caregivers in compliance with Michigan's Licensing Rules for Foster Family Homes and Foster Family Group Homes for Children. Moreover, experienced foster/adoptive and relative caregivers who will be co-trainers with agency staff must attend this training.

To ensure curriculum compliance, a CWTI master trainer observes each trainer conducting a Foster/Adopt PRIDE session. The master trainer evaluates the presenting

trainer and he or she receives an “approval” status upon a successful presentation in accordance with the standards set by the Child Welfare League of America (CWLA).

Foster and adoptive parents also receive ongoing training through community forums, the statewide foster parent association, the Michigan Association of Foster, Adoptive and Kinship Parents’ annual statewide training conference, online training such as “Foster Parent College,” parenting conferences and resource library materials in local DHS offices.

6) Has any training been specifically developed to target improved CFSR or CFSP outcomes, if so, add paragraph stating it.

Child welfare supervisor training covers the intent of the CFSR, which is to promote continuous improvement of the child welfare system. The trainers discuss the intent of the reviews conducted in Michigan in 2002 and 2009 and the outcomes of those reviews, including the federal penalty assessed as a result of the last review. They cover the three phases of the statewide assessment related to the CFSR and the PIP and ongoing monitoring. Finally, the training discusses the areas that the children’s services supervisors need to focus on during their ongoing case reviews so that DHS is in compliance with CFSR standards.

CWTI specifically included a focus on the PIP requirements following the last CFSR and areas needing improvement, and changed training lesson plans as soon as the PIP was approved. CWTI offers coverage in the pre-service and program specific transfer training of child welfare values and improved outcomes around safety, permanency, and well-being. A focus on improving outcomes for children is threaded throughout the curricula and is a specific focus of modules on engagement, case/service planning, Independent Living, “Bringing in the Customer,” and throughout legal and policy and procedure training, based on the assumption that policy has been continuously revised to enhance CFSR outcomes.

Description of estimated total cost

1. For Pre-Service Institute (PSI) only for DHS staff, cost of salary and fringes while in PSI training (paid from a separate line item than regular local office line item).
2. Trainee travel expenses, for DHS staff, for PSI only, for private agencies, for PSI, program-specific transfer training (PSTT), and supervisor training. Local offices are responsible for travel costs for in-service or other training not specified above. Travel expenses include mileage, lodging, and meals.
3. Trainer salaries and fringes.
4. Trainer travel expenses.
5. Guest trainer expenses, including contractual speaker fees and travel costs.
6. Facility rental costs, i.e., when have to rent hotel space because class sizes are too large to be accommodated in our training centers.
7. Binders and materials.
8. Other, including audio-video equipment rental (when we cannot use our own equipment), last minute handouts, etc.

Cost Allocation Methodology
This cost pool is used to accumulate and allocate the costs of administering the Child Welfare Training Institute (CWTI), the DHS mechanism for providing training to Social Services Workers who administer programs for children and youth for whom the DHS is responsible. The cost pool is divided into three segments: 8031.1 for the costs of new Social Services Workers attending initial pre-service training; 801.2 for the costs of administering the Child Welfare Training Institute; and 8031.3 for the costs of the Partial Tuition Reimbursement Program for DHS child welfare staff pursuing Master's of Social Work degrees under DHS auspices.

The CWTI operates under a federally approved title IV-E Training Plan which delineates the curricula qualifying for funding under title IV-E training at 75% Federal Financial Participation (FFP). All of the curricula qualify for title IV-E training funds with the exception of one week of programmatic training in investigative techniques provided only to Children's Protective Services workers. An analysis of the curricula is contained in the approved title IV-E Training Plan.

Cost pool **8031.1** is used to accumulate the costs of Social Services Workers newly appointed to the child welfare and youth programs of Adoption, Juvenile Justice (Delinquency), Foster Care, Children's Protective Services, and Preventive Services during the training period in which they intersperse eight to ten weeks of formal pre-service training in the CWTI with on-the-job training in their home offices. The costs of salaries and wages, fringe benefits, and travel and per diem for newly appointed child welfare and youth Social Services Workers are assigned to Program Code 8744 in the Michigan Administrative Information Network (MAIN), the state's accounting system. When the workers complete their initial training with the CWTI, their salary and wage costs are re-coded to program codes corresponding to the program(s) they are assigned in their local or district offices. The accuracy of the coding is certified one pay period each month by a knowledgeable manager or supervisor.

Participant costs for these new child welfare and youth Social Services Workers are allocated to specific programs by applying the quarterly results of the Staffing Standards Program (SSP) study for each type of worker to the days of training for each type of new worker trained during the quarter. Additionally, one-eighth of the Children's Protective Services worker participation eligible under title IV-E is assigned directly to the Temporary Assistance for Needy Families (TANF) program to account for the one week of training in investigative techniques provided only to these workers in the CWTI Pre-Service Institute.The title IV-E allocable portion of Central Office Administration costs allocated from Cost Pool 06 to Cost Pool 8031.1 is claimed as title IV-E Administration at a rate of 50% FFP.

Cost Pool **8031.2** is used to accumulate the costs of administering and delivering training for the Child Welfare Training Institute. Direct DHS costs are charged to Program Code 8743. These costs include salaries and wages, fringe benefits, and travel and per diem costs for DHS training staff, supplies, printing and publication costs,

and incidental contracts with vendors to provide services and training within the CWTI. Costs for single year or multi-year contracts with outside vendors to provide specific training and coordination of CWTI activities may be charged to Program Code 8747, 8748, or other Program Codes may also be used to track individual contract costs and would be included in Cost Pool 8031.2.

Costs in Program Codes 8743, 8747, and 8748 (and those for other appropriate training contracts) are allocated to specific programs according to the percentage of days of training for each type of worker, other staff member, and other individuals trained during the quarter and by applying the quarterly results of the Staffing Standards Program study for each type of DHS children and youth Social Services Worker. Additionally, one-eighth of Children's Protective Services Worker participation eligible under title IV-E is assigned directly to the Temporary Assistance for Needy Families (TANF) Program to account for the one week of training in investigative techniques provided only to these workers in the CWTI. All DHS Social Services Workers attending the pre-service institute are included in the participant statistics for Cost Pool 8031.2. (Only the new children and youth Social Services Workers in initial pre-service training are included in the statistics for Cost Pool 8031.1)

The title IV-E allocable portion of Central Office Administration costs allocated from Cost Pool 06 to Cost Pool 8031.2 is claimed as title IV-E Administration at a rate of 50% FFP.

Cost Pool 8031.2 is also used to accumulate the travel and per diem costs of Private Child Placing Agency staff attending the CWTI pre-service institute. These costs qualify for title IV-E Administration funding at 50% FFP. The costs are charged to Program Code 8745 and are allocated to specific programs according to the title IV-E/SSBG eligibility ratio of foster care cases for the quarter.

Cost Pool **8031.3** is used to accumulate the costs of partial tuition reimbursement for child welfare workers and supervisors completing a Master's of Social Work degree program. At the present time, DHS is not offering partial tuition reimbursement due to the state's financial straits and no costs are associated with 8031.3 for the current fiscal year. When offered in the future, these workers, supervisors, and any other child welfare personnel coming under the partial tuition reimbursement program must commit to remaining with the agency as child welfare supervisors or workers for at least two years upon completion of their degrees. These costs qualify for funding under title IV-E Training at 75% FFP.

Quarter ending 9-30-08			
Title IV-E Training @ 75% FFP		$901,408.79	31.1668%
Title IV-E Administration @ 50% FFP		$141,550.89	4.8942%
Title IV-A TANF Administration @ 100%		$784,213.42	27.1147%
SSBG Foster Care		$1,065,031.42	36.8242%

Total		$2,892,204.52	100.0000%

Quarter ending 12-31-08			
Title IV-E Training @ 75% FFP		$675,077.82	35.9875%
Title IV-E Administration @ 50% FFP		$57,696.75	3.0757%
Title IV-A TANF Administration @ 100%		$579,008.34	30.8661%
SSBG Foster Care		$564,086.99	30.0707%
Total		$1,875,869.89	100.0000%

Quarter ending 3-31-09			
Title IV-E Training @ 75% FFP		$463,785.23	20.3445%
Title IV-E Administration @ 50% FFP		$208,821.92	9.1602%
Title IV-A TANF Administration @ 100%		$917,375.81	40.2417%
SSBG Foster Care		$689,680.34	30.2536%
Total		$2,279,663.31	100.0000%

Quarter ending 6-30-09			
Title IV-E Training @ 75% FFP		$427,426.64	17.6065%
Title IV-E Administration @ 50% FFP		$500,714.69	20.6254%
Title IV-A TANF Administration @ 100%		$610,944.57	25.1660%
SSBG Foster Care		$888,575.82	36.6021%
Total		$2,427,661.72	100.0000%

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Decision-Making Process on Selection of Service Providers

For central office funded family preservation services such as Families First of Michigan (FFM), the Family Reunification Program (FRP) and Family Group Decision-Making (FGDM), agencies and organizations are selected to provide services based on a contract bid process, under Michigan Department of Management and Budget (DMB) policies. The Request for Proposal (RFP) is drafted with input from a central office program specialist, county program managers, the CPS program office and the DHS Department of Contracts and Rate Setting (DCRS), and contains specific rating criteria for the relevant program and for the geographic area to be served.

The RFP is posted on the DHS public website and a rating committee is identified comprised of program office and county DHS staff and where relevant, other referral sources. Rating committees meet to rate the bids according to DMB contract requirements. Contracts are awarded to agencies that have met all the criteria and achieved the highest score, according to weighted criteria that include quality of the proposal as well as the cost of the proposed service.

Contracts are generally awarded for three-year periods and are monitored by DHS program office staff (Child Welfare Contract Compliance Unit) and family preservation specialists. Bidding agencies' annual reviews (when they have previously provided the service) as well as other service monitoring methods are considered during the rating process.

The agencies selected are community-based, due to their physical location in local communities and, as described in their proposals, their familiarity with local services and service providers, courts, schools, law enforcement, hospitals, and other local programs.

Family support and family preservation services funded through Michigan’s title IVB(2), Child Safety and Permanency Plan and Child Protection/Community Partners funding streams are contracted locally, with county DHS staff preparing the RFP or Request for Quotation (RFQ) with the support of DCRS. DHS and other potential referral services rate proposals as described above and contracts awarded according to DMB requirements.

Child Abuse Prevention and Treatment Act (CAPTA) State Grant

Goal: DHS will negotiate the percentage of improvement for the CFSR Safety Outcome One, Absence of Maltreatment within Six Months, during the development of the CFSR PIP.

CPS Outcome Measures and Results

Measure	Baseline FY 2008	2009*	2010	2011	2012	2013	2014
Number of complaints received	124,716	69,257					
Percent of complaints accepted for investigation	60%	60%					
Percent of investigations resulting in substantiation of abuse or neglect	23%	27%					
Absence of maltreatment within 6 months	92.9%	**					
Absence of maltreatment within 12 months	88.93%	**					

***2009 figures are year-to-date as of 4/30/09.**
****Not available.**

CPS Activities FY 2010 - 2014
The following elements of the DHS' five-year strategic plan to improve CPS services pursuant to CAPTA, Section 106(a) 1 through 14, which Michigan has selected to improve include:

CAPTA Section 106(a) 1. To improve the intake, assessment, screening and investigation of reports of abuse and neglect.

Goal: Centralized CPS Intake
To ensure consistency in response to CPS complaints across the state, the Settlement Agreement requires DHS to implement a statewide 24-hour centralized complaint intake hotline by October 2011.

Centralized intake staff will be responsible for the statewide receipt, screening and assignment for investigation of reports of suspected abuse and neglect. DHS currently operates a centralized intake in Wayne County as well as several other larger counties in the state. DHS has convened a planning committee to implement centralized intake.

Activities:

- Conduct a thorough review of Wayne County intake, which includes examining the process during working hours and after-hours. For example:

    - How much time does it take to complete an adequate clearance of DHS history?
    - How long are reporting persons waiting in the queue?
    - What are the procedures currently in place for assignment of the complaints to the districts?
    - What are the procedures for review of rejected complaints – both at central intake and at the district level?
    - What quality assurance is in place to ensure decisions are consistent across districts?
- Investigate telecommunication issues such as exploring whether it will be necessary to have two locations for centralized intake in case of power outage or other electronic malfunction at one of the sites.
- Ensure quality assurance:
    - What kind of oversight is required for rejected complaints?
    - How can DHS ensure consistency and quality assurance when there are two separate sites?
- Determine of adequate staffing.
- Complete a pilot in Wayne County.
- Ensure appropriate policy and oversight for both the pilot county and statewide implementation.
- Work with Field Operations Administration and Urban Field Operations on the evaluation of central intake.
- Plan and implement a statewide rollout.
- Work with Field Operations Administration and Urban Field Operations, together with the Data Management Unit (DMU) on continuous monitoring and quality assurance of central intake.

Activity: CPS program office will continue to provide technical assistance for field staff while ensuring continued agreements between agencies through collaboration of interagency agreements.

DHS Birth Match Process

The DHS Birth Match Process has been cited as a national best practice for ensuring child safety. The Birth Match process is designed to match childbirths to parents whose parental rights have been previously terminated because of neglect or abuse. This process is designed to assure child safety and allows DHS to identify cases, which, by law, require a child welfare petition because of previous termination of parental rights or because of a history of severe physical abuse.

The Birth Match process uses the Department of Community Health data of new births provided by Michigan hospitals and medical reporters. The process lists all parents on the child's birth certificate in the database and matches those against a DHS file of all parents and/or adults that have severely abused their children and/or have had a past termination of their parental rights. Using cutting-edge technology for this child welfare best practice, the birth match process allows a timely notification via an automatic email

alert to the designated CPS supervisor in each Michigan county where a child is born to a potentially abusive parent.

The information match creates an automatic pre-fill to a CPS complaint in SWSS. SWSS requires an immediate CPS intake worker investigation. The birth match process also provides a means for documenting severe physical abuse, as it includes people who commit severe abuse to a child but who have no legal relationship to the child or no record of termination of parental rights.

The birth match process demonstrates best practice data management for public information technology and is SACWIS compliant.

CAPTA Criminal Background Clearances
Goal: CPS program office will complete child abuse and neglect central registry checks when requested by persons or agencies from out of state.
Activities: Michigan complies with federal requirements for criminal background clearances related to licensing or approving foster care, relative and adoptive placements.

All prospective adoptive families are required to undergo criminal history clearances and child abuse and neglect Central Registry background checks to assure the placement will provide a safe and secure home environment for the child. Adult members of potential adoptive household are also required to submit to background checks, clearances and criminal history checks.

Michigan Licensing Rules for Foster Family Homes and Foster Family Group Homes for Children (R. 400.9205) require a criminal background check and a CPS Central Registry check for all licensed foster and adoptive parents, and other adult household members. Bureau of Child and Adult Licensing (BCAL) will not issue a foster home license and the adoption worker cannot authorize an adoptive placement until the checks are completed. Licensing Rules for Child Placing Agencies (R. 400.12309) also require CPAs to conduct these checks. BCAL conducts annual inspections for each CPA.

Once the foster/adoptive applicant submits fingerprints, they become part of a system known as “RAP back”. If the person commits any criminal activity after the initial fingerprinting, the state police will notify BCAL and routine database matching by the child welfare agency will alert child welfare staff of a match. This process mandates the local office child welfare worker complete a subsequent safety check on the child placed with the family. Additionally, pursuant to the Adam Walsh legislation, DHS workers must conduct a check for substantiated child abuse or neglect in every state where the applicant or any adult household member has lived in the five years preceding the application for licensing.

CPAs must continue to apply the Good Moral Character process to the conviction information received from both the Michigan State Police (MSP) and Federal Bureau of

Investigation (FBI) clearances. If the conviction is for a "specified crime" as defined in R400.1151 and R400.1152, the CPA must prepare an Administrative Review Team (ART) summary and recommendation for BCAL when the CPA continues to recommend licensure or renewal.

In the unlikely event that BCAL staff approves a license for a home with a federally prohibited crime offender under the Adoption and Safe Families Act (ASFA), the foster care program office is notified so they can enter the information into SWSS to prohibit title IV-E payments.

Finally, when an organization applies for a child caring institution license, the facility must comply with all Licensing Rules for Child Care Institutions for an original license to be issued. BCAL clears the chief administrator through ICHAT (a Michigan based criminal history database), the CPS Central Registry and the public sex offender registry (PSOR). The Child Care Organizations Act (PA 116 of 1973) requires a CPS Central Registry check on all employees or volunteers who have unsupervised contact with children. The statute requires an institution to post whether or not they do criminal record checks on employees, but does not require criminal record checks. The rules require the facility to ask about convictions and assess any information they have. Most facilities conduct ICHAT checks on all employees.

The Child Care Institution (CCI) rules are open for revision and the new rules will require an ICHAT check on all employees who have unsupervised contact with children. BCAL is required to complete an annual onsite inspection of every CCI. All personnel files are reviewed for anyone hired since the previous review and a sample of personnel files for current staff are reviewed. The consultant conducts the Central Registry clearance, checks training records, criminal history information, and other requirements, which vary depending on the position. The Michigan licensing rules and PA 116 are located:
http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27720---,00.html

For additional information, reference The Bureau of Child and Adult Licensing and the Substantiated Abuse/Neglect and Use of Corporal Punishment sections.

Section 106(a) 2. Creating and improving the use of multidisciplinary teams and interagency protocols to enhance investigations.

Goal: Finalization of the review, training and determination of an appropriate peer review process to ensure thorough Forensic Interviews of children will occur during the next five-year report period. To improve practice in this area, DHS has initiated the following:

CPS Investigative Protocols
CPS investigative staff is trained in and has access to several protocols that guide investigation. These protocols utilize a collaborative approach and are research based. The protocols have also been developed to address specific issues that have emerged in Michigan. These investigative protocols are described below:

Activities: DHS will work with the Child Welfare Training Institute and other agencies, such as the Prosecuting Attorneys Association of Michigan and the State Court Administrative Office, to design and provide training to public and private child welfare staff related to appropriate use of designed protocols.

A Model Child Abuse Protocol: A Coordinated Investigative Team Approach
In 1993, the Governor's Task Force on Children's Justice (Task Force) created a protocol entitled, "A Model Child Abuse Protocol: A Coordinated Investigative Team Approach" to address the handling of child abuse cases in Michigan. The protocol requires that DHS work with law enforcement and prosecuting attorneys to adopt and implement standard investigation and interview protocols. It was designed to be adapted at the local level, applying guidelines to develop community based interagency child abuse protocols. The protocol was disseminated and trained statewide by a cross-disciplinary team of professionals. After the creation of the protocol, the Michigan Child Protection Law was amended to require its use.

A contract with the Michigan Public Health Institute is in place to conduct a study to determine the extent existing protocols are being adhered to in local communities and if they are not being utilized, what are the barriers to effective use. From this project, a primer on existing protocols will be published and disseminated statewide. The Task Force will ensure statewide, multi-disciplinary training of this protocol, possibly in conjunction with training on the revised Forensic Interviewing Protocol (see below).

Forensic Interviewing Protocol
DHS, in conjunction with Central Michigan University professor Deb Poole, and under the auspices of the Task Force, developed the Forensic Interviewing Protocol. In Forensic Interviewing, children are approached at their age level utilizing neutral words to discern actual events. It is intended for use in conjunction with the Coordinated Investigative Team Approach protocol and is trained in law enforcement and child welfare disciplines. After the development of the Forensic Interviewing Protocol, the Michigan Child Protection Law was changed to require its use when interviewing children during CPS investigations.

In 2004 and again in 2009, the Task Force, along with non-Task Force members, completed a reassessment of the Forensic Interviewing Protocol and its implementation. Changes made to the protocol are based on the updated information gained during the assessment. The first revised document was published and disseminated statewide with training on the revised protocol. The Task Force continually evaluates the need to update the interviewing protocol to assure it meets appropriate guidelines for interviewers needs. The protocol is in the final stages of a third revision. Over the next five years, activities will continue to finalize the protocol, ensure appropriate training and to put into place a "peer review" program to ensure that interviews are completed in accordance with the protocol.

Goal: CPS program office will update the Munchausen Syndrome by Proxy (MSBP) document as needed to ensure accuracy of the information for use by field staff.

Munchausen Syndrome by Proxy: A Collaborative Approach to Investigation, Assessment and Treatment

To address risk in families that include complex medical and psychological issues, the Task Force developed a protocol type document titled, “Munchausen Syndrome by Proxy: A Collaborative Approach to Investigation, Assessment and Treatment”. This document encompasses the identification of MSBP and establishes guidelines for each discipline potentially involved in a MSBP case investigation. The professionals involved in a MSBP case may include the court, law enforcement, medical staff, CPS workers, attorneys, and psychologists.

Absent Parent Protocol: Identifying, Locating, and Notifying Absent Parents in Child Protective Proceedings

The Task Force developed the Absent Parent Protocol to provide guidance for identifying and locating absent parents of children involved in the child welfare system. The protocol is a response to a broad based consensus that failure to identify and involve absent parents is a barrier to timely, permanent placement for children. The protocol provides information on the need to, and methods of, locating absent parents to ensure that all viable placement options for children are considered. The Absent Parent Protocol is covered in training provided by the CWTI and is considered standard practice in child welfare cases when placement is being considered (Reference the Coordination between the Title IV-E and the Title IV-D Programs and the Child Welfare Training Institute sections).

Goal: Where specific activities are not noted above for the protocols, DHS will address barriers to the effective use of investigative protocols and will provide training and technical assistance where needed in the field.

Child Injury and Death Coordinated and Comprehensive Investigation Resource Protocol

The Task Force developed the Child Injury and Death Coordinated and Comprehensive Investigation Resource Protocol to provide information to ensure coordinated investigation in child maltreatment cases, including child maltreatment cases that result in a child death. Additionally, the protocol addresses ways to minimize additional trauma to child victims during the investigative intervention. The protocol is a compilation of summaries on existing child abuse and neglect protocols and the entire Sudden and Unexplained Child Death Scene Investigation Form. These protocols provide information and guidelines directed towards responders from different disciplines including law enforcement, CPS workers, prosecutors, and others. They reflect current successful methods to conducting thorough coordinated investigations of child maltreatment cases. The goal of the protocol is to promote the highest level of effective handling of child maltreatment cases through clearly defining team roles, appropriately carrying out responsibilities, initiating consistency in dealing with children and families,

and increasing the understanding and appreciation of the unique roles of each discipline involved.

Methamphetamine Protocol
The Methamphetamine Protocol was developed by a multi-disciplinary workgroup to ensure that the health and safety of children found in or near methamphetamine laboratories is addressed consistently and appropriately. The environmental contamination and hazardous life styles of a methamphetamine lab setting create numerous risk factors for children, and may result in abuse, neglect and/or health endangerment. This protocol addresses the immediate health and safety needs of children, establishes best practices and provides guidelines for coordinated efforts between DHS workers, law enforcement and medical services.

These protocols are available for statewide dissemination at any time. Copies are available from DHS. PDF versions of the guide are also available on the DHS Web site. These protocols and additional CPS publications can be found:

http://www.michigan.gov/dhs/0,1607,7-124-5458_7699---,00.html

Goal: DHS will continue to improve legal preparation and representation through training as well as publication and distribution of resource materials.

Section 106(a) 3. Improving legal preparation and representation.
In collaboration with the Task Force, DHS provides an array of training opportunities and child welfare resources specifically geared to address legal issues relating to child welfare. These trainings are planned through agreement with the SCAO (Reference the Court Improvement Project and the Child Welfare Training Institute sections).

L-GAL/Parents' Attorneys Trainings: At least two training sessions for legal guardians ad litem and parents' attorneys are planned per year for the future, depending on continuing need and interest. It has been suggested that holding the training regionally with cross-professional county teams may be a more effective way of distributing information and enhancing cross professional communication and efforts. **(Children's Justice Act [CJA] Grant funded)**

Prosecutor/Attorney General Training: One training is planned each year for the future, depending on continued need and interest. **(CJA Grant funded)**

Specialized Training for Legal Professionals: Between April 29, 2009 and June 4, 2009, six CFSR regional trainings were conducted for state and tribal judges and court staff to inform the courts about their role for the upcoming CFSR, which is scheduled to take place in the fall of 2009. "Representing Parents in Child Protective Proceedings: How Effective Advocacy Can Further the Best Interests of Children", will be offered in each even year. **(CJA Grant funded)**

Children's Charter of the Courts of Michigan Contract: In February of 2009, the Task Force approved a contract with Children's Charter of the Courts of Michigan to provide

for an update and conversion to an electronic version of a publication entitled, "Guidelines to Achieving Permanency in Child Protective Proceedings", commonly known as the "Yellow Book". The publication is a recognized resource for courts, attorneys, child welfare advocates, Court Appointed Special Advocates, and child welfare professionals. It is currently in its fourth edition.

The purpose of the contract is to update the Yellow Book with statute changes, as well as convert the paper book to an electronic format. This format will allow for making timely updates to the Yellow Book as well as provide efficient communication of changes, and a more efficient process for maintaining the currency of the Yellow Book. **(CJA Grant funded)**

Child Welfare Law Journal: The Task Force provides partial funding for the publication and quarterly distribution of the Child Welfare Law Journal. The Journal focuses on an interdisciplinary approach to child welfare. The Journal's content revolves around practice issues and is distributed to professionals working in the field of child welfare, including social workers, DHS county offices, attorneys, psychologists, and medical professionals. **(CJA Grant funded)**

Section 106(a) 4. Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families. To improve in this area, DHS has instituted the following:

Team Decision-Making (TDM)/Permanency Case Conference (PCC)
Michigan continues to integrate the principles of family engagement through its use of TDM/PCCs, which are a crucial component to facilitating a family centered, strength based and team guided decision-making process (Reference the Case Practice Model section).

Activities: To implement Concurrent Permanency Planning (CPP) statewide, DHS staff will:

- Conduct focus groups with staff DHS and private agencies, foster parents (both licensed and relatives and Native American tribes.
- DHS developed the policy with input from the CPP workgroup and several consultants from Casey Family Programs. Draft policy for the pilot is completed and approved.
- Engage birth family through TDMs and other family meetings.
- Assist in the development and training for the state.
- Assess and evaluate pilot counties.
- Add additional counties for statewide implementation.
- Work with Field Operations Administration, Urban Field Operations and Quality Assurance Unit to ensure continued success for children and families.

Concurrent Permanency Planning (CPP)
Public Act 202 of 2008 amended MCL 712a.19 to allow DHS to implement concurrent planning. Concurrent permanency planning (CPP) aims to expedite permanency for Michigan's children. It involves:

- The front loading of services and other intense work on family reunification.
- Concurrently, establishing a back-up permanency plan in case the child cannot return home safely.

In July 2008, DHS staff formed a CPP Committee, with representatives from the State Court Administrative Office (SCAO), the courts, DHS, private child placing agencies (CPA), Native American Affairs (NAA) and Child Welfare Training Institute (CWTI). DHS also received technical assistance from the Casey Family Programs and Michigan State University's School of Social Work. During the first phase of implementation, DHS will use CPP in all cases with the goal of reunification. DHS may choose to implement concurrent planning for other case goals later. In June 2009, Clinton and Gratiot counties will pilot CPP.

In conjunction with SCAO, the kickoff event for CPP was held on March 10, 2009. The training included DHS and court staff. Linda Katz, ACSW, one of the creators of the concurrent planning model, discussed the concepts and methods of utilizing concurrent planning. Judge Leonard Edwards of California, nationally known for his judicial leadership in concurrent planning, also discussed his experience with concurrent planning. Other highlights of this program included:

- Principles and concepts of concurrent planning for all professionals involved in child welfare cases.
- Overcoming perceived conflicts with the concurrent planning model of services.
- DHS implementation of concurrent planning.
- The importance of parenting time and parental involvement with the concurrent planning process.

SCAO provided training to court personnel in June 2009. Reference the Permanency section for additional information on DHS' permanency-planning efforts.

Section 106(a) 5. Enhancing the general child protective system by developing, improving and implementing risk and safety assessment tools and protocols;
See previous section on numerous DHS protocols and the Case Practice Model section for information on the SDM risk and safety assessment tools.

Section 106(a) 6. Developing and updating systems of technology that support the program and track reports of child abuse and neglect.
Activity: CPS program office will continue to work with the Data Management Unit (DMU) to ensure SWSS CPS and other systems are appropriate for field staff and to ensure continued success for children and families.

Section 106(a) 7. Developing, strengthening and facilitating training, including research-based strategies to promote collaboration, the legal duties of such individuals and personal safety training for caseworkers.

Goal: To collaborate and provide training statewide.
Activities: DHS will continue to participate in the planning and provision of numerous training opportunities and conferences for child welfare professionals in the state of Michigan, including, among others, the Annual Child Abuse and Neglect Prevention Conference that is held in Plymouth. **(CAPTA funded)**

CPS program office will continue to participate in the collaborative training committee for CWTI to ensure appropriate training courses are provided.

Summits
A yearly summit conference will continue for state legislators and other policy makers on current issues pertaining to the investigation and judicial handling of child abuse/neglect and child sexual abuse in Michigan. The next Summit will be in September of 2009 and between 150 and 180 child welfare professionals are expected to attend.

The theme for the 2009 Summit will center on infant and child brain development, and the impact of child abuse on brain development. Dr. Bruce Perry from the Child Trauma Academy in Houston, Texas, will be the featured speaker. Sessions will include Michigan Early On program, neuroscience issues in older children and how they affect their ability to participate in legal decision-making, pending child welfare legislation in Michigan and the impact of the legislation if enacted. **(CJA Grant funded)**

Training for Child Welfare Professionals
The Task Force, through DHS, developed an interagency agreement with SCAO to provide child welfare training to child welfare professionals through established and developing curricula, training modules, conferences, interactive web casts and video presentations, and to write, print, distribute, and implement protocols, resource guides, practice manuals, and other materials related to such training (Reference the Court Improvement Project and the Child Welfare Training Institute sections).

The following is a list of some of the activities and specialized trainings planned through the interagency agreement for 2008-2009:

Summer Series Training Sessions: Cross-professional workshops and trainings focusing on a specific theme are offered each summer. **(CJA Grant funded)**

- Handling the Child Welfare Cases – Applying the Law to Practice (for LGALs/parent's attorneys). **(CJA Grant funded)**
- Handling the Child Welfare Cases – Applying the Law to Practice (for prosecuting attorneys and Attorneys General). **(CJA Grant funded)**
- Representing Parents in Child Protective Proceedings: How Effective Advocacy Can Further the Best Interests of Children. **(CJA Grant funded)**

- Medical Issues in Child Maltreatment: Things Judges and Lawyers Want to Know but Never had a Chance to Ask. **(CJA Grant funded)**
- Child and Family Services Review (CFSR) regional trainings. **(CJA Grant funded)**
- Representing Parents in Child Protective Proceedings: How Effective Advocacy Can Further the Best Interests of Children. **(CJA Grant funded)**
- Post Termination Proceedings – Post Termination Reviews and Adoption. **(CJA Grant funded)**
- Michigan's Forensic Interviewing Protocol for Legal Professionals. **(CJA Grant funded)**
- Title IV-E Training for county DHS and court staffs. **(CJA Grant funded)**
- Concurrent Planning: A Unified Approach for Providing Permanency to Children. **(CJA Grant funded)**
- Legal Issues Regarding Fathers' Involvement. **(CJA Grant funded)**
- Implementing the Absent Parent Protocol and What to Do About Incarcerated Parents. **(CJA Grant funded)**
- Engaging Fathers: Resources and Programs for Full Engagement. **(CJA Grant funded)**
- Addressing Invisible Injuries: Child Neglect, Exploitation, and Emotional Abuse. **(CJA Grant funded)**

Other specialized trainings through DHS will include:

- Contract with the PAAM to provide ten mandated reporter trainings around the state. **(CAPTA funded)**
- Support of local DHS offices across the state in their efforts to train mandated reporters of child abuse and neglect for school, medical, law enforcement, and other personnel in the communities. **(CAPTA funded)**
- Continuing collaboration with the Michigan Department of Education (MDE) and the Michigan Public Health Institute (MPHI) to educate and train school personnel in each school district in Michigan regarding mandated reporter responsibilities. **(CAPTA funded)**

The Task Force identified a need for assistance with travel costs for child welfare trainings. With the current economic climate in Michigan, and the reduction of DHS funds in combination with other cost saving measures, the Task Force continues to approve the use of Children's Justice Act Grant funds to allow DHS staff or tribal workers to attend any Task Force funded and endorsed training. The Task Force also extended this funding to private CPA caseworkers as well.

Section 106(a) 8. Improving the skills, qualifications and availability of individuals providing services to children and families and the supervisors of such individuals through the child protection system, including improvements in the recruitment and retention of caseworkers.

Goal: Task Force will distribute cameras via DHS program staff to foster care workers and expects to complete distribution by the end of the fiscal year. Program office will continue to explore means of ensuring that field staff has the tools necessary to ensure

thorough and complete CPS investigations and documentation of all issues within a child welfare case.

Digital Cameras for Child Welfare Caseworkers
In 2008, the Task Force began the process of funding the purchase of digital camera packages, memory cards and camera cases for both DHS and private CPA foster care workers. The camera packages are being distributed at a rate of one camera for every four workers. The cameras will assist foster care workers in documenting any evidence they may find regarding the children on their caseloads, as well as used to update yearly photographs of the children, and provide evidence to the court regarding case plan progress and other issues, as necessary.

Section 106(a) 9. Developing and facilitating training protocols for individuals mandated to report child abuse or neglect.

Goals:
- DHS will continue to participate in a collaborative manner related to the educational campaign for mandated reporters.
- DHS will continue to work collaboratively with the CTF to incorporate mandated reporter awareness and education into its activities and projects.

Together with the Citizen's Review Panel for Prevention, DHS is working on education for mandated reporters of child abuse and neglect. Exploratory work included reviewing public service announcements from other states, and developed a Request for Proposal for an educational campaign. The panel has further obtained information from a marketing expert to explain the process and give suggestions for a large-scale educational campaign. Bids for a marketing campaign were due in mid-May 2009.

DHS has developed and maintains a Mandated Reporter's Resource Guide and Web site and is working with the Children's Trust Fund (CTF) to incorporate mandated reporter awareness and education into the activities the CTF facilitates as a part of Child Abuse Prevention and Awareness Month. The DHS Mandated Reporter Web site is located:
http://www.michigan.gov/dhs/0,1607,7-124-5452_7119_7193_7812-157836--,00.html

Section 106(a) 10. Developing, implementing or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions.

Goal: DHS will continue the Medical Advisory Committee and the contract with the Medical Resources Services contract. The Medical Advisory Committee will review both CPS and foster care policies and procedures and make recommendations as to how DHS can best meet the medical and health needs of the children that are served.

The Medical Advisory Committee was developed in 1996 in response to CPS workers needing consultation with medical professionals who specialize in child abuse and neglect (CA/N) examination, diagnosis, and treatment. This committee was responsible

for the development of the Medical Resource Services (MRS) contract in 1999 and also develops and organizes the annual Medical Advisory Committee Conference. The purpose of the annual conference is to educate physicians and medical professionals, and facilitate discussion on medical issues related to CA/N. Participants in the committee include representatives from the CPS Program Office and several physicians throughout the state that specialize in CA/N.

The committee meets bi-monthly and provides a forum to discuss a variety of medical issues pertaining to CA/N. Topics of past meetings have included CPS policy, child malnourishment and the use of psychotropic medication for children.

Committee meetings are also used to discuss and respond to general medical questions from the field. Questions and potential agenda items are sent to the CPS Program Office, which seeks answers and, in turn, provides them to the caseworkers. Medical Advisory Committee members are primarily medical care professionals whose expertise is in the field of pediatrics and/or child abuse and neglect. Membership is open to these professionals when interested in participation.

Further, DHS addresses medical and health issues through the continuation of the contract with the Child Protection Team at DeVos Children's Hospital through the Medical Resource Services (MRS) contract.

Goal: DHS will continue to refer children on substantiated CPS cases to the Early On program. Early On program staff will continue to work with the Data Management Unit to develop an appropriate database system that will accurately compile the data that is needed to continue to evaluate the services provided to children and families, in addition to the demographic information related to the children served by the program

Early On
DHS is compliant with a provision in the Child Abuse Prevention and Treatment Act (CAPTA) of 2003 by referring all children from birth to three years who are victims in Category I and II CPS preponderance of evidence cases. This referral begins an eligibility assessment process, with services provided as appropriate. In 2008, DHS referred 3,096 children to Early On.

Section 106(a) 11. Developing and delivering information to improve public education relating to the roles and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect.

Goal: Program staff will continue to act as technical assistance to the field related to education of the public regarding the role of the CPS worker and the CPS program with children and families. Program staff will seek opportunities to present information to the public or specific professional groups related to the CPS program as well.

See Section 106(a) 9 above.

Section 106(a) 12. Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

Goals:

- DHS will continue to work with the Citizen Review Panel (CRP) on Children's Protective Services, Foster Care, and Adoption and the CPS Advisory Committee to improve CPS policy in order to improve the goals of safety and well-being for the children served by CPS. The policy revisions will be implemented through consultation and collaboration with field staff and other stakeholders. Policy is revised up to twice a year to incorporate new programs, initiatives or trends, and to provide staff with direction designed to allow them to carry out their responsibilities as effectively and efficiently as possible.
- From 2010 to 2014, DHS will continue to change policy as necessary, guided by changes in the Michigan Child Protection Law. DHS will urge changes in the law and in policy as driven by the needs of the children at risk along with the input of community stakeholders.

Citizen Review Panel (CRP)

The Citizen Review Panel (CRP) on Children's Protective Services, Foster Care, and Adoption is a subcommittee of the Governor's Task Force. The panel focused on two issues, with recommendations made to DHS, during calendar year 2008:

The panel agreed to function as Michigan's stakeholder group for the CFSR Statewide Assessment and CFSP. The panel collaborated on developing CFSP, including identifying areas of weakness identified, including cooperation with Native American tribes and medical consultation for children in foster care. In addition, the panel focused on the education of mandated reporters. (See Section 106(1)9.)

Goal: In response to a recommendation from the Office of Children's Ombudsman and based on information from the Citizen Review Panel on Child Fatalities, CPS program office will review cases in which the child fatality involved unsafe sleep conditions. The purpose of the review is to determine if guidelines can be developed to assist CPS workers investigating fatalities involving unsafe sleep conditions. A secondary purpose is to determine a means by which DHS, in collaboration with the Safe Sleep Statewide Advisory Committee, may influence a change in attitude and action within the general public that will adequately prevent infant sleep deaths.

Citizen Review Panel (CRP) on Child Fatalities

The CRP on Child Fatalities was established by law in 1999 by the federal government to provide an opportunity for citizens to aid in ensuring that states meet goals of protecting children from abuse and neglect. The CRP evaluates the strengths, weaknesses and challenges in the child welfare delivery system and meets quarterly to

review identified cases of child abuse and neglect that have occurred within a given year. Annually, CRP compiles findings and recommendations to DHS for consideration.

The CRP on Child Fatalities met eight times in 2008 and reviewed 149 child deaths that occurred in Fiscal Years 2006 and 2007. Of the 149 cases reviewed, 64 (43 percent) were found to be child maltreatment deaths and 21 child abuse and 43 neglect. This means that of the 64 cases found to be child maltreatment, almost 67 percent were neglect.

The CRP and the foster care fatality reviews completed by the DHS Office of the Family Advocate have resulted recommendations for changes in DHS policy and procedure. DHS has developed and continues to implement new protocols to improve the quality of CPS investigations. The initiatives outlined below are in development:

- **SWSS CPS Child Death Alert and Report**. This new software enhancement format collects child death information in a timely manner and notifies key DHS personnel. The information collected at intake and at disposition of an investigation is stored into a secure database accessed by the DHS Data Management Unit. This new process promotes consistency and accuracy of data collection.
- **SWSS FAJ Child Death Alert and Report.** The initial steps of programming have started on software to create a notification system that will also allow DHS to collect accurate child death information for children under the care and supervision of DHS for foster care, juvenile justice or adoption services in a similar manner to the SWSS CPS format. The information collected prior to case closure will be stored in a secure database accessed by the DHS Data Management Unit.
- **Infant Safe Sleep.** To promote infant safe sleep, DHS and community sponsors have initiated multiple education efforts. DHS sponsored a safe child/safe sleep campaign for the prevention of child deaths as data identified that half of the child deaths in Michigan in 2001 were preventable. Identified risk factors in child deaths included the lack of smoke detectors, poor prenatal care, drug or alcohol use during pregnancy, unsafe sleep environments, poor supervision and inappropriate selection of babysitters. A significant portion of these at risk families have contact with the local DHS offices for public assistance, food assistance, Medicaid and other services distributed by DHS.

  Based on these findings, the DHS prevention campaign to educate customers on creating a safe environment for children continues. The local offices have brochures, lobby videos and other resources readily available to clients and providers that were developed by the CPS program office. The identified education programs are home safety, shaken baby syndrome and creating safe-sleep environments for children.

  DHS also maintains the Infant Safe Sleep Web site: www.michigan.gov/safesleep.

Goal: DHS will continue to provide training and resources to improve timely, thorough and consistent child death investigation to caseworkers and supervisors.

- **Child Death Investigation Training.** A two-day training covering child death investigations, uniform definitions, new protocols, and prevention efforts is offered

annually for CPS investigators, medical examiners, law enforcement and other professionals. **(CAPTA funded)**

- **Child Death Investigation Checklist (DHS-2096).** DHS developed a comprehensive investigation checklist for CPS workers and supervisors to use to ensure that CPS child death investigations are thorough, timely and consistent with applicable laws and policies. **(CAPTA funded)**

Goal: DHS will continue to work with MPHI to refine the death review process and identify DHS policy changes and CPS investigative protocols needed to prevent future harm to children in Michigan. DHS will also work with MPHI to ensure the child death annual report is completed each year.

Michigan Child Death State Advisory Committee
The Michigan Child Death State Advisory Committee reviews the findings and data from local Child Death Review (CDR) teams. The goal of the review is to make recommendations for policy and statute changes and to guide statewide education and training efforts to prevent future child deaths.

Child Fatalities – Safety
Current Child Protection Law allows the establishment of local CDR teams and defines their membership to include at least one medical examiner, a representative for the local law enforcement, a DHS and local public health representative, and the prosecuting attorney or designee. Since 1990, the total number of child deaths in Michigan has declined by 36 percent. The Child Death Review program has recommended 276 prevention strategies and implemented 141 of the recommendations.

Largely due to improvements in the reporting of child deaths, there has been a steady increase in the number of child deaths in Michigan that were identified as attributed to child abuse and/or neglect.

Children's Trust Fund
Michigan's third Citizen Review Panel is the Children's Trust Fund (Reference the Children's Trust Fund section).

Section 106(a) 13. Supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment.

Goal: To improve delivery of service and treatment between the child protection and juvenile justice systems.

The CPS Program Office is currently working on a project with the Governor's Task Force on Juvenile Justice in which a review of educational neglect at a national, statewide and county level is occurring. The project is working on the following activities

to determine how best to meet the needs of families with young children who do not attend school as required by law:

- Review of statutes and policies in other states related to educational neglect.
- Review of local/county programs that have been used historically in Michigan to deal with the issue of educational neglect.
- Determine what programs have been successful and which have not.
- Determine what services are most successful for families in which this type of issue is prevalent.
- Review Michigan statutes and policy and make recommendations related to appropriate means of dealing with this issue on a statewide level.
- Take action to ensure recommendations are brought to fruition.

The Federal Compliance Office within DHS is working with the Bureau of Juvenile Justice (BJJ) to create and modify dual ward policy and practice. The Youth Services Unit is also collaborating with BJJ on CFCIP and ETV funds. Furthermore, the Data Management Unit is working on the integration of juvenile justice data into a single data repository (Reference the Data Management section on page 172).

Section 106(a) 14. Supporting and enhancing collaboration among public health agencies, the child protection system and private community-based programs to provide child abuse and neglect prevention and treatment services.

Goal: The Governor's Task Force CPS subcommittee will continue to work toward goals set in its strategic plan to improve casework practice in the areas listed below:

The Collaboration, Coordination and Problem Solving (CCPS) subcommittee of the Task Force met numerous times to revise and enhance its strategic plan. The CCPS subcommittee met with DHS' Director for Children's Services to align the Task Force strategic plan to DHS initiatives, including Settlement Agreement requirements. There are several new action steps associated with the plan that pertain to experimental, model, and demonstration programs that the Task Force would like to initiate during the next CJA report period which may continue into the 5 year CFSP report period. They include the following:

- Identification of Fathers: This action plan involves collaboration between title IV-D (funding for the prosecution of paternity cases and processing affidavits of parentage) and title IV-E (funding for child abuse/neglect cases) program areas to provide for early identification of fathers. This early identification of fathers would assist in several areas including earlier permanency for children, additional placement options and knowledge of a child's genetic/medical history (Reference the Coordination between the title IV-E and the title IV-D Programs section).
- Appropriate Disposition Plans: This action plan involves obtaining early, appropriate assessments across domains, which the worker can then use to develop a dispositional plan tailored to each family's individual needs. The assessments used should be evidence-based or promising practices in research loops.
- Reunification/Safety Plans: This action plan involves addressing common issues that often delay reunification, including physical health/disabilities, substance abuse,

domestic violence, and mental health. With an appropriate safety plan in place, children could return to the care of their parents. The safety plans should be evidence-based or promising practices in research loops.

- Assessment Pilot: This action plan involves finding or creating a standardized, validated assessment tool for children in different domains such as mental health, occupational therapy, developmental, etc. The tool would be geared toward DHS' "permanency backlog cohort" (a group of permanent court wards awaiting permanency who are a priority because of the Settlement Agreement), with a long-term goal of using the assessment at disposition for all children. The pilot would involve the permanency backlog cohort. The Task Force will collaborate with others currently working on these types of assessments. The assessments would eventually correspond to child's medical passport. (Reference the Health Services Plan and The Permanency Planning Unit sections for additional information).

In collaboration with the Task Force and others, additional CPS goals for FYs 2010 through 2014 include:

Policy Activities: Many changes are made to CPS policy during each year. Not all changes alter the specific meaning of the policy but may ensure that hyperlinks are up-to-date and that policy is clear and ordered logically. Some examples of the more significant changes over the years have been:

- Policy on when to obtain a medical examination in sexual abuse cases was clarified.
- Policy was modified to ensure that a thorough evaluation of the non-custodial parent's home is done prior to placement.
- Complaints alleging that methamphetamine is being smoked in a home where children reside must be assigned for investigation.
- Policy was added outlining when mental health information must be redacted.
- Policy on completing out-of-state central registry clearances was added to ensure compliance with the federal Adam Walsh Child Protection and Safety Act (PL 109-248).
- Policy was added on mandated reporting to ensure that DHS employees are reporting suspected child abuse and neglect and adult abuse, neglect and exploitation as required by the Child Protection Law and the Social Welfare Act.
- A definition of torture was added to define when a petition needs to be filed, as required by the Child Protection Law, when torture has occurred.
- Criteria that must be met in order to assign a complaint for investigation was added to improve consistency in the assignment of complaints and to ensure the Child Protection Law is followed when determining whether or not assign a complaint for investigation.
- Policy was added that requires completion of a safety assessment and face-to-face contact with all alleged child victim(s) prior to requesting:
  - Approval for an extension of the 30-day standard of promptness.
  - Requesting reauthorization of a previously approved extension.
  - Disposing of an overdue investigation.

Goal: DHS will modify CPS policy in accordance with changes in the Child Protection Law and encouraging changes to protect children at risk more effectively. The ongoing

improvement of CPS policy continues through consultation and collaboration with field staff and other stakeholders. Policy is revised up to twice a year to incorporate new programs, initiatives or trends, and to provide staff with direction designed to allow them to carry out their responsibilities as effectively and efficiently as possible. CPS program office will also work with Field Operations Administration and Urban Field Operations to determine what is necessary to improve the performance of the field staff related to safety measures of the CFSR.

Goal: DHS will work toward decreasing the number of children in out of home care/foster care and increase the role of parents and families throughout the TDM/PCC process, while increasing the use of appropriate relative care placements.

Goal: DHS will increase public awareness of the dangers of placing infants to sleep in an unsafe sleep environment. DHS will continue to attend the Statewide Safe Sleep Advisory Committee, which is a multi-agency collaborative group that works to advocate for education of the public on this issue.

Goal: Efforts are still being made to educate families on the risk of Sudden Infant Death Syndrome. An interagency group developed the Safe Sleep Statewide Advisory Committee to promote this initiative. Safe Sleep Kits were distributed statewide. These kits will include posters, brochures, toy cribs and baby dolls, reminder door hangers, and an informational DVD. The DHS Lobby Video DVD is in the process of being updated. Local offices can request additional materials on infant safe sleep from CPS Program Office. The previously launched Infant Safe Sleep Web site (www.michigan.gov/safesleep) is updated regularly by CPS program office.

Goal: The Governor's Task Force will educate and influence policy makers at the national, state and local level to promote positive outcomes for abused and neglected children through continued communication with legislators and policy makers on Task Force initiatives and issues and through identifying partners within the legislative process to support Task Force initiatives and issues.

Section 106(b)(2) Case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families.

CAPTA State Grant

Describe the steps the State agency will take to expand and strengthen the range of existing services and develop and implement services to improve child outcomes. Explain planned activities, new strategies for improvement, and the method(s) to measure progress under CAPTA Section 106(b)2.

Goal: The DHS Children's Protective Services program continues collaborating with Michigan State University to develop separate mandated reporting guides for several disciplines, including school personnel, physicians, and pediatricians.

- The previously developed Web site for mandated reporters (www.michigan.gov/mandatedreporter) is updated when necessary.
- Efforts are currently being made to educate the public on the role and responsibilities of the child protection system and the basis for reporting suspected incidents of child abuse and neglect. Examples of the activities that will continue are:
  A. Contract with the Prosecuting Attorney's Association of Michigan to provide mandated reporter trainings around the state. **(TANF funded)**
  B. Support of local DHS offices across the state in their efforts to train school, medical, law enforcement, and other personnel in their communities. **(CAPTA funded)**
  C. The Mandated Reporter's Resource Guide will be updated as necessary. Local DHS offices were sent copies of the guide and more can be ordered, as needed. **(CAPTA funded)**
  D. Through the previous work with the Michigan Department of Education and the Michigan Public Health Institute, in 2008, every school superintendent received a packet of information that included a recommendation to contact the local DHS office to request a presentation for their school staff on the reporting requirements under the Michigan Child Protection Law. Each local DHS office has staff available to do such presentations. This training will continue to be provided at a local and statewide level as requested. **(CAPTA funded)**
  E. Work with the Governor's Task Force on Children's Justice to begin a mandated reporter awareness campaign. **(CAPTA funded**, Sec. 107.)
  F. Work with the Children's Trust Fund to incorporate mandated reporter awareness and education into the activities the Children's Trust Fund facilitates as a part of Child Abuse Prevention and Awareness Month. **(CAPTA funded)**
- All trainings and activities related to CPS program office will be maintained by the office and reported to the bureau director via in annual report.

Policy
An annual child death report, which is a compilation of all the reviews of child deaths in Michigan within a specific year, is written and widely disseminated to key stakeholders involved in child welfare. The report outlines recommendations on policy, legislation, and procedures designed to reduce the number of preventable deaths. Specifically, issues such as parental rollover deaths, fetal drug exposure resulting in death, and violence are areas critical for future study.

Describe the services to be provided, highlighting any changes or additions in services or program design and how the services will achieve program purposes.

Goal: To improve DHS access to pediatric medical services to aid in the assessment of child abuse and neglect. (See below for past activities that will be continued in this report period).
Activities: The Medical Resource Services (MRS) continues and the contract was most recently renewed in 2008. The Child Protection Team at DeVos Children's Hospital was awarded the contract. The MRS contract has two parts:

- A 24/7 hotline for caseworkers and physicians who need verbal or written consultation on cases involving medical issues related to child abuse and/or neglect. A physician is always on call if direct consultation is needed.
- The development of a statewide medical provider network so that all counties in Michigan will have local/regional medical resources.

In FY 2008, the MRS contract provided the following services: 794 triage contacts, 85 case reviews, two-second opinions, 285 patient encounters, 337 physician consults, and 44 network referrals. DeVos Children's Hospital is diligently working on developing a medical provider network.

Goal: Collaborative Activities in Children's Protective Services include:
Governor's Task Force on Children's Justice (GTF or Task Force)

The Governor's Task Force was appointed in Michigan in 1992 with the purpose of meeting the federal requirements of a state multidisciplinary task force under the Children's Justice Act. The Task Force continues to be involved in the development and implementation of programs and initiatives related to child abuse and neglect, the protection of children and overall child welfare. See Sections 106(a)2-5, 7-9, 11, 12 and 14.

Goal: To improve the skills, qualifications, and availability of staff and supervisors providing services to children and families. (See below for past activities that will be continued in this report period).
Activity: Program-specific training designed exclusively for supervisors was developed in 2006 to train supervisors in monitoring staff performance, policy, case reading, and using data and reports to assess unit and individual worker performance.
The provision of this CPS Supervisor Training was completed in December 2006. At least 90% of all CPS supervisors were trained during the initial rollout of the training. The training has continued quarterly during the fiscal years 2007 and 2008 for new supervisors and supervisors not trained during the initial rollout.

The CPS Supervisory training was updated and is now a competency based 40 hour training curriculum (trained over 5 consecutive days) that is required of all child welfare supervisors hired after April 1, 2009 and current supervisors that have not previously had supervisory training. Days 1 and 2 consist of general material applicable to all child welfare supervisors and days 3-5 are program specific. At the conclusion of the training, the supervisor is required to take and pass a competency-based evaluation.

Activity: CPS policy has been revised in cases where domestic violence is present to place priority on the safety of the child and the non-offending parent. This policy change places focuses on assessing the safety of the child, the response by the non-offending parent, the completion of a safety plan, and holding the perpetrator accountable.

Goal: To provide technical assistance provided to counties and other entities that operate state programs.

Activity: Please see information on training under the Governor's Task Force on Children's Justice (above and in Section 106(a).).

Goal: Continued development and enhancement of the Social Worker Support Systems technology that supports all child welfare programs and develops and maintains reports will continue. In addition, an interface between the public assistance system, Bridges, and the Social Worker Support System is in progress.

Activity: Michigan's State Automated Child Welfare Information System (SACWIS) Service Worker Support System (SWSS) for CPS was rolled out statewide in November 2007. SWSS-CPS makes reporting and data compilation easier and allows for intrastate information exchange. CPS program office, with input from DHS field staff continue to work with the Data Management Unit that now houses SWSS-CPS to ensure policy compliance through continued improvement of the system.

CPS program office manager acts as the co-chair for a collaborative committee involving DHS staff, CPA staff and central office staff to ensure that systems decisions made are appropriate and adequate for field staff to ensure the best service to children and families.

Goal: Continued improvement of CPS field staff related to thorough CPS interviews and investigation.

Activity: In conjunction with the Michigan State Police and DHS Office of the Family Advocate and the Child Welfare Training Institute, the CPS Program Office assisted in the development of the two-day course, "Advanced Interview and Investigation Training." The training was initially presented by the Michigan State Police and Child Welfare Training Institute instructors. The training focuses on the following issues:

- Safety awareness, communication, and verbal de-escalation.
- Evidence collection and documentation.
- Pre-interview preparation.
- Interview techniques.
- Truthful versus deceptive behavior/responses.
- Advanced interviewing techniques.

The training was provided to all CPS workers and supervisors and was completed in September 2008. In February 2009, the training was added as a module of new worker training institute. Any existing workers and supervisors that did not receive the training during the initial rollout are able to attend the session offered during the new worker institute.

Goal: CPS program office will work with the Child Welfare Training Institute (CWTI) and field staff to ensure that this successful training continues as a module for workers who attend training by CWTI as well as to determine whether additional training sessions are required to meet the needs of the front line field staff and their supervisors.

Goal: Improved investigative tools for CPS field staff.

In conjunction with the Michigan State Police, the DHS Office of the Family Advocate and the Child Welfare Training Institute, CPS Program Office developed a Field Guide

for Child Protective Services workers. The guide is intended to be used in the field by CPS workers during investigations.

Activity: The Field Guide will continue to be updated to incorporate policy changes as policy and laws are amended.

Other CAPTA supporting activities include those completed in conjunction with the Governor's Task Force on Children's Justice (GTF or Task Force).

Health Care Services Plan

Overview

All children are entitled to health services that identify their conditions and needs, diagnose and treat identified problems and initiate appropriate follow-up and preventive health care. As a result of health care deprivation and abuse and neglect, nationally, children in foster care experience a high level of health services needs.[1] Recent research provides the following statistics:

- Approximately 60 percent of children in care have a chronic medical condition, and 25 percent have three or more chronic problems.[2]
- Developmental delays are present in approximately 60 percent of preschoolers in foster care.[3]
- Children in foster care use both inpatient and outpatient mental health services at a rate 15 to 20 times higher than the general pediatric population.[4]
- Between 40 percent and 60 percent of children in foster care have at least one psychiatric disorder.[5]

It is not surprising that those children entering foster care display higher rates of physical and emotional problems than children in the general population do. Compared with children from the same socioeconomic background, they have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement.[6] These problems may be due to conditions that existed before entry into foster care (abuse and neglect, inadequate health care, etc.) and are exacerbated when adjusting to placement outside the home or multiple placements that interrupt the consistent receipt of medical and/or mental health services.

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[1] *Working Together*: Health Services for Children in Foster Care, NYS Office of Children and Family Services, 2009, p. xi

[2] M. Szilagyi. "The pediatrician and the child in foster care," *Pediatric Review* 19 (1998), pp. 39-50. N. Halfon, A. Mendonca, & G. Berkowitz. "Health Status of Children in foster Care: The Experience of the Center for the Vulnerable Child," *archives of Pediatrics & Adolescent Medicine* 149 (April 1995), pp. 386-392.

[3] Ibid.

[4] S. DosReis, J.M. Zito, D.J. Safer & K.L. Soeken. "Mental Health Services for Youths in Foster Care and Disabled Youths," *American Journal of Public Health* 91:7 (2001), pp. 1094-1099. J.L. Takayama, A.B. Bergman, F.A. Connell, "Children in Foster Care in the State of Washington: Health Care Utilization and Expenditures, *Journal of the American Medical Association* 271 (1994), pp.1850-1855. N. Halfon, G. Berkowitz, & L. Klee. "Mental Health Services Utilization by Children in Foster Care in California," *Pediatrics* 89 (1992), pp. 1238-1244.

[5] DosReis, 2001.

[6] Administration for Children, Youth and Families. *Child Welfare Statistical Fact Book.* Washington, DC: US Office of Human Development Services; 1984

ASFA provided a federal legislative framework to give new direction and parameters to child welfare agencies and the courts. The CFSR is the federal monitoring and evaluation component of ASFA. The CFSR process measures the achievement of states on the well-being outcomes for children in foster care as well as safety and permanency. These well-being outcomes hold states accountable for the timely and adequate provision of medical, dental and mental health services for children in foster care. Most recently, The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351) places additional emphasis on agencies to provide ongoing oversight and coordination of health care services for children in foster care, including their mental and dental health needs.

Call for Reform

In Michigan, the Settlement Agreement emphasizes the importance of DHS monitoring the provision of health services to foster children to determine whether they are of appropriate quality and are having the intended effect. By October 2009, DHS will take all necessary and appropriate steps to ensure that each child entering foster care receives:

- Needed emergency medical, dental and mental health care.
- A full medical examination within 30 days of the child's entry into care.

The DHS Health Services Plan is designed to establish continuity of health care for children in foster care and ensure a comprehensive and coordinated treatment approach by all professionals involved in their care. The Health Services Plan sets forth specific action steps to ensure that each child entering foster care receives:

- A screening for potential mental health issues utilizing a valid and reliable tool within 30 days of entry into foster care and a referral for a prompt further assessment by an appropriate mental health professional for any child with identified mental health needs as indicated by the screening tool.
- All required immunizations, as defined by the American Pediatric Association, at the appropriate age.
- Periodic medical, dental and mental health care examinations and screenings, according to the guidelines set forth by the American Pediatric Association.
- Any needed follow-up medical, dental and mental health care as identified.
- An established medical home.

DHS has been meeting with them the Department of Community Health monthly since last November and collaborated on creating the Health Services Plan. The collaboration has also been focused on the transition of foster children from straight MA to managed care. DHS has also been meeting with the mental health leadership at DCH to discuss how mental health services identified through the DHS needs assessment would be provided.

Current foster care policy and licensing rules provide general health requirements for DHS and private CPAs to ensure that each child has:

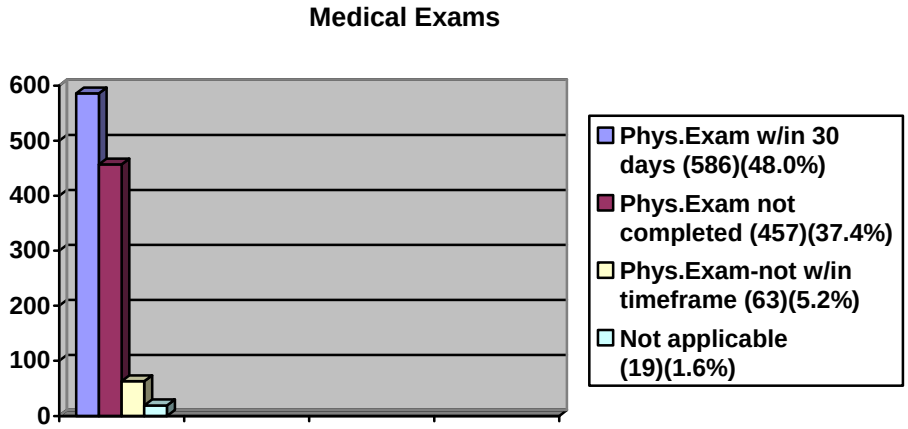
- A physical examination within 30 days of initial foster care placement (CFF 722-2).

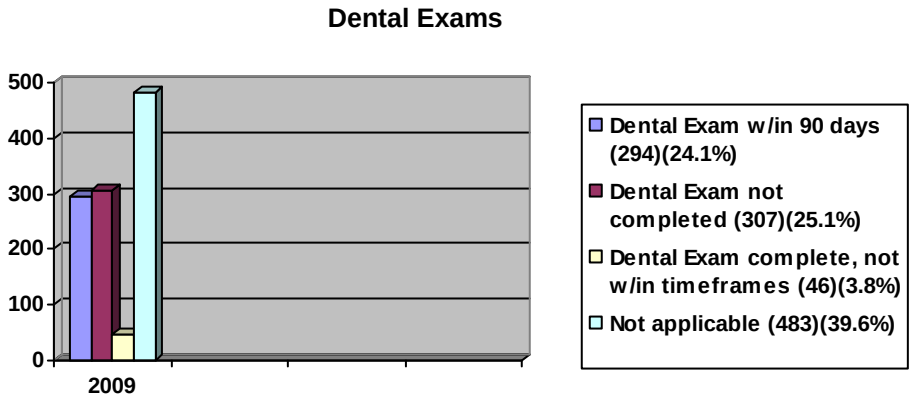
- A dental exam within 90 days of placement if the child is 4 years old or older (CFF 722-2).
- Current immunizations (CFF 722-2).

There are also policy requirements to document all medical, dental and mental health care received, including information regarding prescriptions, and maintain a medical passport for each child that is provided to caregivers. A child's present health status and medical needs are required at the child's placement into foster care. CPS workers make every effort to obtain the medical information outlined in the "SWSS Transfer to Foster Care Module, Medical and Transfer Needs/Services", in preparation for placement. If the information is not available, it is the responsibility of the foster care worker to obtain the medical information. (CFF 722-6).

Historically, it has been particularly difficult to collect data regarding health care information for a number of reasons. When a child is removed, the removal household is either unwilling or unable to provide the caseworker with a complete medical history. High caseloads with numerous requirements for services have affected the time a worker spends entering data into SWSS. This often resulted in case record entries being blank particularly for those areas where the worker does not have information. Without health information being consistently available or entered by the caseworker, a complete assessment of current practice and adherence to policy is not available. In addition, DHS purchases 38 percent of foster care casework supervision from private CPAs. Currently, private CPA workers cannot access SWSS to input medical information. Data is entered into SWSS by DHS purchase of service (POS) caseworkers for private agency cases, but medical information is not a mandatory completion module in SWSS and oftentimes, the information is missing.

To develop a baseline and future performance targets for improved health care delivery, DHS is using data collected in preparation for the CFSR Statewide Assessment for the upcoming CFSR. Approximately 1200 foster care cases were read by supervisors statewide and by the FCRB between 11/1/08 and 1/31/09. The results of the case readings support that children are not always receiving medical and dental services as required by policy (Reference the Title IV-E Compliance section).





Implementation of a health care system that provides accessible, quality care is the goal of our service provision.

Accessibility:

- Routine medical care should be available within a short distance from placement settings.
- Providers offer flexible and non-traditional hours of service.
- Foster children should have consistency in their health care and access to a medical home.
- Providers need to be identified who are willing to conduct comprehensive medical examinations within a 30-day timeframe.
- DHS staff carries caseloads that allow them to monitor the scheduling, follow up of appointments, and provide assistance with transportation if needed.
- Caregivers need to be trained that health care is a priority.

Quality Care:

- Children in foster care should receive high quality medical and mental health care.
- Quality of care should be monitored by a variety of sources: interviews with caregivers, Medicaid and other qualified stakeholders, as well as being maintained electronically within SWSS.
- Child health care professionals must understand the unique culture of foster care that includes:
  - Removal from all that is familiar.
  - The impact on all aspects of health and well-being.
  - Diversity of racial, ethnic, cultural, and linguistic background among children and their caregivers.
  - Federal and state regulations and laws that govern the child welfare system.

Integration:

- Collection of health care information should be integrated into existing venues, such as TDMs.
- Attention to health care needs to be integrated into services to children as a whole.

Collaboration:

- Foster parent training to share health care values and support is fundamental.
- Engage in partnerships with the DCH to share data and resources.

Developing a quality health care system that meets the well-being of foster children requires a commitment to build an infrastructure that can provide strong coordination of children's health needs and services. Building an infrastructure is based upon lowering DHS caseloads, revising the organizational structure to include a medical director and expanding the pool of available placements. While the desire is to address all the problems that negatively impact the provision of quality health care services to foster children, the reality is that we cannot move forward and hope to sustain efforts if the infrastructure cannot support the change. We will need to move forward cautiously and coordinate the health care services plan with the progress made in building the infrastructure.

Health Care Access

All foster children are Medicaid eligible, but a number of years ago a decision was made to exempt this population from enrollment in managed care because of problems associated with the frequent moves of this population, and enrolling and disenrolling from various health plans when placement moves occur. If a child is on Medicaid prior to removal and enrolled in managed care, the registration and enrollment in straight Medicaid might mean a delay in getting Medicaid information to the placement caregiver. Without Medicaid information, foster parents and other caregivers are unable to schedule needed medical or dental appointments.

Public Act 246 of 2008, Sec. 1772 called for DCH to establish and continue a program to enroll all children in foster care in Michigan into a Medicaid health maintenance organization (HMO). DHS has been working with DCH since March 2008 to implement this boilerplate. There will be benefits to foster children when enrolled in an HMO:

- Twelve of Michigan's Medicaid Health Plans were ranked in the Top 50 in the United States by U.S. News & World Report in 2008.
- With enrollment in an HMO, there is a significant reduction in visits to the emergency room.[7]
- HMOs provide transportation services.
- Mental health coverage is available for up to 20 visits a year.
- Early Periodic Screening Diagnostic and Testing (ESPDT) is done for all children.
- There is continuity of a medical home.

DCH is implementing a new Medicaid Management Information System (MMIS) system within the same timeframes as DHS is implementing our new integrated eligibility system (Bridges). DCH is represented on both the steering committee and in the program office for the Bridges project to ensure the necessary interfaces are maintained

[7] Zuckerman S, Brennan N, Yemane A. "Has Medicaid Managed Care Affected Beneficiary Access and Use?" *Inquiry.* 2002;39(3):221–42.

and policy changes are handled appropriately. SWSS passes child information through Bridges to the DCH MMIS. Until Bridges is completely rolled out, the movement of foster children to HMOs cannot successfully occur.

During this planning phase for the continuing enrollment of foster children in HMOs, DHS and DCH have the opportunity to work collaboratively to design managed care models to fit the needs of children in foster care. A meeting is scheduled in July 2009 to begin work on the models. DHS recently hired a medical director, Zakia Alavi, M.D., who will be on board August 24, 2009. Dr. Alavi is a child psychiatrist, who brings her past experience and expertise working with children in child welfare to the job. Dr. Alavi will meet with James Dillon, M.D., Director of the Office of Psychiatric and Medical Services at the Department of Community Health and Mike Head, Director of the Mental Health and Substance Abuse Administration of the Department of Community Heath, on August 31, 2009. With the expertise and input of a DHS medical director, we will develop contracts, set capitation and case rates and define the makeup of provider networks to address the special needs of children in custody. We will also work together to ensure that there are mechanisms to solve problems and to ensure continuity of care when a child changes placement.

At DHS, we will need to develop protocols and structures within local offices in response to the transition of foster children to managed care. There needs to be a point person or expert in each office serving as the face of the agency to work with the HMOs. A local office expert could also ensure timely health care access for children served by private agencies. The local office expert needs to:

- Know all the available HMOs.
- Facilitate the enrollment and disenrollment process.
- Ensure that established health care procedures are followed.
- Track health outcomes.
- Assess family, child and provider satisfaction.
- Make improvements based on data and outcomes.

An important outcome of these new protocols and structures will be to ensure continuity of health care services. Every effort will be made to ensure that a medical home is established for each child.

A DHS Health Committee comprised of the Medical Director and Field Operations and Foster Care Program Office staff will convene in fall 2009 to begin this work. With careful planning, access to health care for foster children will improve when the transition to HMOs occurs. The current date for the implementation of the DCH boilerplate is October 2009, but delays in Bridges could affect that date.

Because the implementation date for the transition of foster children to managed care is contingent on the complete rollout of Bridges, a two-pronged approach to improving health care access is in place. In addition to the transition of foster children to managed care plan outlined above, DHS staff began meeting in April 2009 to develop an interim strategy. A “Health Care Survey” is under development and will be used to monitor the

timely receipt of Medicaid cards by caregivers, and to solicit information from caregivers about timely access to quality health care for foster children. Each month the DHS Survey Center will contact a random sample of caregivers with newly placed foster children by phone or by mail. The caregivers will be asked questions about receipt of Medicaid cards, how long it took to get the cards, difficulty in scheduling medical and dental appointments, quality of the care received and questions about the mental health needs of children in their care, and the responsiveness of the agency and community to those needs. The surveys will be conducted from September 2009 to March 2010. The information from the surveys will be used to identify counties in the state that fall below performance targets set by the DHS Health Committee. In these counties, we will examine the existing health care delivery system and develop individualized plans to improve services to foster children in those counties.

The Medical Advisory Committee was developed in 1996 in response to CPS workers needing consultation with medical professionals who specialize in child abuse and neglect (CA/N) examination, diagnosis, and treatment. This committee was responsible for the development of the Medical Resource Services (MRS) contract in 1999 and also develops and organizes the annual Medical Advisory Committee Conference. The purpose of the annual conference is to educate physicians and medical professionals, and facilitate discussion on medical issues related to CA/N. Participants in the committee include representatives from the CPS Program Office and several physicians throughout the state that specialize in CA/N. Medical Advisory Committee members are primarily medical care professionals whose expertise is in the field of pediatrics and/or child abuse and neglect. Membership is open to these professionals when interested in participation.

The committee meets bi-monthly and provides a forum to discuss a variety of medical issues pertaining to CA/N. Topics of past meetings have included CPS policy, child malnourishment and the use of psychotropic medication for children. The committee has also addressed the health needs of children entering the foster care system. Through this active involvement with medical professionals, DHS has amended policy to serve better the health and well-being of children in care.

Even though the Medical Advisory Committee has provided valuable guidance, plans are underway to assemble a Medical Advisory Panel that will be geared toward children in foster care. Once on board, the Medical Director of DHS will assemble this Medical Advisory Panel to actively consult with and involve physicians and other appropriate medical and non-medical professionals specifically in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

Mental Health Screening

The provision of mental health services for foster children is fragmented. The public DCH system does not have sufficient financial resources to serve the number of children needing mental health services. Currently, by contract, CMH serves children diagnosed as seriously emotionally disturbed who meet the medical necessity criteria

for the Medicaid specialty clinic and rehabilitation services contained in the 1915(b) waiver and the specialty services for priority populations included in the Mental Health Code, i.e., children who have more severe emotional and behavioral disorders.

Children covered by Medicaid with mild to moderate mental health disorders are typically served by the HMO for up to 20 visits (outpatient) utilizing their plan benefit. However, since foster children are disenrolled from the HMO plans upon placement, this benefit is not currently available to them. DHS recognizes that abused and neglected children in child welfare are not receiving effective, comprehensive mental health services and supports to meet their needs.

At the worker level, all children are screened for mental health issues within the first 30 days of entering care, and quarterly thereafter, using the Child Assessment of Needs and Strengths (CANS). This tool is a part of the SDM system developed for Michigan by the National Council on Crime and Delinquency, The Children's Research Center (Reference the Case Practice Model section). Using provided definitions, workers score a child's mental health status. If the score is a negative number, it indicates a mental health need for the child. The top three negative scores on the CANS must be addressed in the child's service plan and services must be provided to meet the need. The CANS is a consensus-based assessment. The Settlement Agreement requires that screening for potential mental health issues occur within 30 days of entry into foster care utilizing a standardized, validated tool.

In an effort to address children's mental health needs, a Mental Health Screening Pilot Project with DCH began in the summer of 2007. Ingham and St. Joseph counties have been screening foster children with the Ages and Stages Questionnaire-Social Emotional (ASQ-SE) or Pediatric Symptom Checklist, depending on the age of the child, since the fall of 2008. Preliminary data supports that 32 percent of children entering foster care require a mental health assessment as indicated by the initial screening. DHS and DCH will analyze the pilot results to determine if these tools are effective for screening the mental health issues of foster children and consider expansion of the pilot sites by July 2009.

Once foster children are transitioned to Medicaid managed care, mental health screening will be included as part of the Well Child/EPSDT Program, which is included in current HMO contracts. The required Well Child/EPSDT screening guidelines are based on the American Academy of Pediatrics' recommendations for preventive pediatric health care. Also included in the current contracts is the requirement to make appropriate referrals for a diagnostic or treatment service if determined to be necessary.

Immunizations

Immunizations are considered routine medical care and do not require a parents' authorization. However, some parents, acting in accord with state laws, refuse to have their children immunized because of religious beliefs. If this is the case, a signed statement from the parents specifying the prohibition must be contained in the case record.

The AAP recommends an immunization schedule that is congruent with the Michigan Medicaid Program. In addition, there is a schedule of required childhood immunizations for Michigan school settings that serves as a minimum standard for children in custody. Current policy requires parental or Michigan Children's Institute consent for the human papillomavirus vaccine (HPV).

Goal: DHS will utilize the expertise of its medical director to evaluate all recommended immunizations to determine their appropriateness as preventive health care for foster children.

The Michigan Child Immunization Registry (MCIR) is a statewide practice by DCH to track the immunizations of all children in the State of Michigan. Doctors and health departments are able to update the system as immunizations are given. Since March 2005, SWSS automatically downloads data from DCH to get up-to-date information on immunizations for foster children. This information includes the immunization and date given. If a worker encounters documentation that is not on MCIR, a process is in place to add the information. This prevents duplicate or missed immunizations.

Psychotropic Medication

Children placed in the custody of the Michigan Department of Human Services often have biological, psychological and social risk factors that predispose them to emotional and behavioral disturbances. The use of psychotropic medication as part of a comprehensive mental health treatment plan may be beneficial. However, caution must be used in administering psychotropic medication to children in DHS custody because of heightened concern due to publicized cases where questionable prescribing patterns threaten a child's health. Policies and procedures to guide the psychotropic medication management of children in DHS custody will be made in consultation with child and adolescent psychiatrists. The Michigan Department of Community Health will collaborate with DHS to provide the system oversight of psychotropic use.

System Oversight of Psychotropic Use

Comprehensive NeuroScience, Inc. (CNS) is a privately held company, specializing in research, care management, and education related to central nervous system disorders. CNS actively invites collaboration and contact across multiple spheres, including academia, government agencies, and with members of the biopharmaceutical and commercial healthcare industries, as well as financial and investment communities. In 2002, CNS developed the Behavioral Pharmacy Management (BPM) process to ensure the quality of expanded prescribing given the tremendous increases in utilization of medication to treat behavioral illness.

The BPM evaluates mental health medication pharmacy claims to identify prescribing patterns that are inconsistent with national, evidence-based practices. The state and CNS work together to identify prescription patterns. Eli Lilly and Company provides financial support for the initiative, while the operation and implementation of the program is done solely by the state and CNS. More than half of the nation's states have taken part in this program.

The program sends educational materials to doctors who deviate from national prescribing guidelines, and also informs doctors when their patients fail to fill prescriptions in a timely fashion. Physicians who continue to experience the same issues over time are offered peer consultation to discuss prescribing practices.

The Michigan Department of Community Health's (MDCH) BPM is called the Pharmacy Quality Improvement Project (PQIP). The PQIP was launched in May 2005 and analyzes the prescribing of mental health medications for Medicaid adult and child members and identifies prescribing patterns inconsistent with evidence-based guidelines. In 2006, the program was expanded to include opiate drugs.

PQIP is a collaborative effort involving the MDCH Mental Health and Substance Abuse Administration and the Medical Services Administration, in partnership with CNS. Eli Lilly and Company provides funding in support of this independent program. The MDCH Mental Health Advisory Committee, composed of medical directors from the Medicaid Health Plans and the Prepaid Inpatient Health Plans, serves as an advisor to the project.

The PQIP process includes a monthly review by CNS of Medicaid patient pharmacy claims data to identify prescribing and utilization trends for mental health and opiate medications. Researchers look at categories such as multiple medications prescribing in the same therapeutic class, prescribing above or below FDA-recommended dosing levels, failure of patients to fill their prescription in a timely fashion, and patients with two or more physicians prescribing the same medications during the same time period. Prescriptions that fall within these categories are compared with best practice guidelines. Physicians who prescribe outside the best practice guidelines are provided with educational materials as well as opportunities for peer-to-peer consultations.

An impact analysis was performed comparing claims costs before and after a PQIP intervention between May 2005 and January 2006. The results showed a 22 percent reduction in claims and a 21 percent reduction in costs were both realized during the time period.

In October 2007, CNS modified the maximum dosing levels recommended for children and adolescents. CNS convened a panel of providers to evaluate and develop an accepted dosage of behavior health medications for these populations.

The PQIP is scheduled to end in November 2009. MDCH has not yet made a decision regarding its continuation. Without the financial support of Eli Lilly, resources might not be available to fund CNS for the monthly review of Medicaid patient pharmacy claims data. Our medical director plans discussions with MDCH, which will focus on a joint effort to continue the project. It might be possible to approach Eli Lilly for funding to focus on the foster care population.

Psychotropic Medication Management Policies and Procedure
The DHS medical director is a child psychiatrist who will guide the development of policies, procedures and oversight of psychotropic medication management of children in DHS custody.

Goal: By November 30, 2009, DHS will update policies and procedures surrounding the use of psychotropic medications.

Data Collection and Monitoring
Goal: In monitoring the health needs of foster children, it is apparent that inconsistent data exists to provide a full picture of current practice. Data that is more complete is a goal during this five-year plan.

Data entry into SWSS for children in foster care is inconsistent. Workers can leave the "Child Info" module of SWSS and move to other modules without entering any health information. In February 2009, a SWSS work requirement was submitted to the Department of Information Technology to improve the collection of health information. The worker will receive a prompt to complete health information before he or she can leave the "Child Info" module. Additional fields will also be added to the module to document mental health information and prescription medication. A policy change will be implemented by October 2009 requiring the DHS worker to enter all health information into SWSS.

Virtually all DHS foster children have Medicaid as their medical insurance. A rich source of health data for foster children is available via Medicaid payment claims at DCH. A data sharing agreement between DHS and DCH is being drafted that will allow DHS to have access to claim data that will provide a more complete picture of the health care services that foster children receive. Future planning includes a SWSS interface with DCH for Medicaid claim information.

Monitoring access to and provision of health care services is an important facet of planning. The DHS Health Committee will identify an oversight process by October 2009 utilizing some of the current processes in place and supplementing the oversight as needed. DHS will ensure that performance based contracts address the provision of health care services and develop a quality assurance process when services or reporting by private agencies is not adequate. Supervisory review and other types of oversight need to include a review of electronic information entered into SWSS.

Goal: A two-pronged approach to implementation is being employed to bring about timely reform. DHS will work closely with DCH to assure a successful movement of foster children to HMOs, while continuing to implement interim strategies to improve health care delivery and oversight. Over the next two years, the reform will yield an improved health care delivery system that meets the physical and mental health needs of every child in foster care.

Chafee Foster Care Independence Program

Description of Program Design and Delivery

The Chafee Foster Care Independence Program goals (CFCIP) are addressed through the Youth in Transition (YIT) program by the Michigan Department of Human Services (DHS). The YIT funded services provide support to youth in foster care and increases opportunities for youth transitioning out of foster care through collaborative programming in local communities. The DHS will cooperate in national evaluations of the CFCIP.

The eligibility criteria for Chafee and Educational Training Voucher (ETV) funded services is documented in the Michigan Department of Human Services foster care manual (FOM) under the sections titled The Youth In Transition (YIT) Program (FOM 950) and Educational Training Voucher (ETV) Program (FOM 960). All youth meeting the criteria for Chafee funded services are eligible regardless of race, gender, or ethnic background. To further assure all eligible youth are provided Chafee funded services, the DHS Youth Services Unit developed a form, DHS 722: Youth in Transition – Youth Eligibility Checklist, for caseworkers to use when determining a youth's eligibility for Chafee funded services. The DHS 722 will be released in October 2009 along with an instructional "L" letter directing workers to complete a DHS 722 within 60 days of the youth's 14th birthday.

For "Room and Board," payment is defined and provided at a lifetime limit of $1,000 for the first month's rent, utility and damage deposit. Changes to the FOM 950 policy will be released in December 2009 and include the stipulation that no more than 30 percent of a local DHS office's Chafee (YIT) allocation may be spent on housing.

Describe the State of Michigan's Medicaid coverage for youth transitioning out of foster care.

As of May 1, 2008, Michigan extended automatic Medicaid eligibility to youth leaving foster care at 18 until their 21st birthday. The DHS dedicated a staff position and developed a one-page form the caseworker faxes to Central Office to open Foster Care Transitional Medicaid (FCTMA). A FCTMA brochure was developed for youth and has been provided to all local DHS offices. Private and public agency CPA caseworkers provide the brochure to youth prior to their exit from the child welfare system. This brochure also serves as a guide for caseworkers. Training for caseworkers statewide is in progress as is mailing of information to notify all youth who have transitioned from foster care and are eligible for FCTMA.

Counties are migrating to a new data system that will automatically open foster youth for FCTMA. By October 1, 2009, all local DHS offices are expected to have this capability allowing for a seamless referral process.

Describe the specific accomplishments and progress to establish, expand, or strengthen the State's postsecondary educational assistance program to achieve the purpose of the ETV program.

- During the 2008 fiscal year, the ETV staff completed 25 Outreach Activities. These activities included the ETV annual regional meetings, foster care youth job and career fairs, mass informational emails to DHS and private agency caseworkers, and presentations to Youth Boards.
- In order to ensure that all youth applying for the ETV will have funding, a process and procedure was put in place to provide funding for the fall and winter semesters that is consistent with other educational fund sources.
- The ETV staff provided direct case management services to approximately 50 of the ETV recipients. Thorough assessments of the youth are completed, enabling Michigan to recognize the lack of supports for the youth. The case manager and the youth address each youth's needs by making referrals and directing youth to available resources such as:
    - Budgeting and financial management.
    - Relationship building.
    - Job assistance.
    - Tutoring.
    - Financial aid assistance.
    - Locating housing.
    - Services available on campus.
    - Academic assessments.
    - Filling out required college applications and forms.

- The Foster Youth in Transition website (www.michigan.gov/FYIT) provides information and links about the ETV Program. The MDHS also provides additional outreach to the community through the Independent Living Coordinator and foster care case managers in each of the 83 counties.
    - In FY 2008 **551** youth received the ETV, an increase of 22%.
    - **52.4% (289)** of the youth who were awarded the voucher received ETV for the first time.
    - **23% (128)** of the youth received it for the second time.
    - **14.8% (82)** of the youth received it for the third time.
    - **9.4% (52)** of the youth received it for a fourth or fifth year.

Indicate how the ETV program is administered whether by the State child welfare agency, in collaboration with another State agency or with an outside entity such as Orphan Foundation of America.

- The Chafee ETV Program is a state administered program that is implemented through a contract with Lutheran Social Services of Michigan (LSSM) since 2006. In June 2008, a new contract proposal was placed for bids, according to Michigan Department of Management and Budget guidelines. This process resulted in a three-year contract with LSSM from October 1, 2008 to September 30, 2011.The program is administered by an ETV case manager and an ETV Coordinator. DHS Youth Services Program Office monitors the program.

- LSSM maintains a database and website (www.mietv.lssm.org) that streamlines the application process. Youth have three options to receive an ETV application: online, downloading a paper application, or calling a toll-free number to request an application (1-877-660-METV).
- The disbursements of the ETV vouchers are made directly to the postsecondary institutions, vendors, or in some instances, the youth. When funds are issued to vendors such as property owners or car insurance agencies, third party checks are written. This allows the youth to be responsible in managing the funds. In some instances, funds are provided for needed living expenses such as groceries. In these cases, the youth is responsible to provide copies of receipts that verify the funds were spent on the intended purpose.
- LSSM provides the necessary services to assist a youth in completing an ETV application. LSSM developed relationships with community partners such as state agencies, postsecondary institutions, and private foster care agencies.

Goal: Michigan DHS will involve the public and private sectors in helping adolescents in foster care achieve self-sufficiency through the following collaborative activities during FY 2010 through 2014:

- The DHS Youth Services Unit will develop a committee of DHS and private Child Placing Agency (CPA) staff and transitioning youth to develop child welfare policy for the Youth Service Delivery Model (YSDM). This model provides a coordinated continuum of services for youth ages 14-21 in foster care and transitioning from foster care. The YSDM is based on the "permanency teaming concept". Permanency teaming draws in the community, committed adults, peer advocates, and family members to support the youth in attaining permanency and self-sufficiency by adulthood.

Objectives:

- By September 2009, finalize the development of the Youth Services Delivery Model utilizing expertise from the Jim Casey Youth Opportunities Initiative, the Finance Project, and the Casey Family Services.
- Identify and solicit DHS and private CPA staff to implement Phase One of the Youth Service Delivery Model to begin October 1, 2009 (FY 2010).
- By January 2010, train and involve DHS and private CPA staff and supervisors in the model and utilize data from the Michigan Youth Opportunities Initiative (MYOI) to highlight and replicate successful practices. Bi-annual trainings will occur, with quarterly webinars or face-to-face one-day trainings.
- Expand the model each year to ensure DHS and CPA staff and stakeholders will be using the model statewide by FY 2014.

Measurement:

- By September 30, 2009, the following committees comprised of DHS, CPAs, courts, and transitioned youth will be developed to oversee and support the implementation of the Youth Service Delivery Model.
  1. Steering Committee: Oversees the implementation of the model and ensures the efforts of the three action teams as noted below are coordinated.

2. Practice, Policy, and Training Committee: Develops the policies, practices, and documentation that will guide the field through the implementation of the model and delivery of training.
3. County Preparation, Internal Communications and Messaging Committee: Develops a communication plan and message to prepare counties for the implementation of the model.
4. Data, Evaluation and Quality Control Committee: Compiles baseline data, ensures an analytic system is in place for data entry, evaluates the outcome data, and recommends best practices that are data driven.

- By October 15, 2009, four Youth Service Delivery Model pilot sites will complete the Permanency Teaming Training. The identified pilot sites are Macomb, Genesee, and 23 counties in the former Region 1 (Upper Peninsula) and Region 2 (Northern Lower Michigan).
- By December 1, 2009, the YSDM will be finalized and shared with DHS Directors, District Managers, Supervisors, and private CPA managers across the State of Michigan.
- By October 1, 2010, twenty percent (20 %) of the Permanency Teaming trainees will be staff from private child placing agencies.
- By January 1, 2011, the remaining three (3) urban counties, Oakland, Kent, and Wayne Counties will complete the Permanency Teaming Training and begin implementing the YSDM.
- By October 1, 2011, the remaining 14 largest counties will complete the Permanency Teaming Training and begin implementing the YSDM.
- By September 30, 2014, the remaining counties will complete the Permanency Teaming Training and begin implementing the YSDM.

Goal: Involve youth in the designing and implementation of YIT funded services and the Youth Service Delivery Model.

Objectives: The DHS Youth Services Unit will complete the following:

- Implement the Youth Service Delivery model (see above) statewide by September 30, 2014 for youth ages 14-20 in foster care and transitioning from care.
- Continue youth involvement through youth boards, Michigan Youth Opportunities Initiative (MYOI), youth participation in statewide committees with input on the Youth Service Delivery Model and legislative presentations.
- Develop and implement the Youth State Advisory Committee (YSAC) by November 1, 2009. The YSAC will make recommendations for systemic changes, identify the outcomes and support the implementation of system changes. The YSAC will meet quarterly. Youth ages 18-20 will be the primary target group fro the YSAC.
- By October 1, 2010, develop and implement an executive team of youth trained in communication, media, and leadership and advocacy skills for each youth board.
- By September 30, 2010, support and develop an annual *Youth Voice* publication to identify youth priorities for practice and policy development.

- By September 30, 2010, support and develop a web-based youth networking capacity for youth boards as well as to facilitate individual youth communication.
- By October 1, 2012, provide technical assistance and encourage each county, dual-county or region with a youth board to develop a monthly youth-driven newsletter or ensure access to neighboring county's youth newsletter.
- By October 1, 2013, develop and implement robust youth boards that meet monthly in each urban, dual-county cluster, or regionally based geographic area.

Measurement:

- By October 1, 2010, ten (10) counties will be identified as MYOI sites and trained in the MYOI or youth and community engagement piece of the Youth Service Delivery Model.
- By January 1, 2010, the Youth State Advisory Committee will conduct the first quarterly meeting. Documentation of the YSACs priorities, recommendations, and system reform will be summarized yearly in the Annual Progress and Services Report (APSR).
- Beginning June 2010, two youth media and two advanced youth media trainings will be held annually.
- By September 30, 2010, YSAC representatives will meet with the legislature one time to advocate for policy and practice changes affecting older youth in care and transitioned from care. Legislative meetings will occur annually thereafter.
- By September 30, 2010, ten Michigan youth boards will develop web pages in collaboration with the Foster Club.
- *Youth Voice III* will be published by September 30, 2010 and annually thereafter.
- By October 1, 2010, five new youth boards will be developed. By October 1, 2014, 20 new youth boards will be developed.

Michigan also coordinates with other federal and state programs for youth, specifically transitional living programs funded under Part B of the Juvenile Justice and Delinquency Prevention Act of 1974, in accordance with Section 477(b)(3)(F) of the Act.

Goal: Improve coordination between state and federal programs for youth.

Objectives: The DHS Youth Services Unit will:

- By November 1, 2009, develop and implement the state team to reduce teen pregnancy for foster youth, adopted youth, youth in guardianship, and closed case foster youth. The core team will include stakeholders from the Department of Community Health (DCH), Michigan Department of Education (MDE) and former foster youth, one of whom was a teen parent while in foster care.
- By November 1, 2009, through a collaboration with the Corporation for National and Community Service and several local DHS offices, fifteen (15) AmeriCorps VISTA Volunteers will be selected to develop mentoring programs, increase the number of community partners actively supporting youth, develop community service opportunities for youth, and develop supportive housing services for closed case youth. Local DHS offices were selected to receive VISTA Volunteers based on whether they were a pilot site for YSDM, a Michigan Youth

Opportunities Initiative (MYOI) site, high poverty rate, a need for housing resources for youth transitioning from foster care, and where the location of most of the youth ages 14-20 in foster care are located.

- Continue collaborating with the Michigan State Housing Development Authority (MSHDA) regarding joint grant applications, such as the Family Unification Program for housing choice vouchers for youth.
- By August 2010, develop policy with the MDE by to improve the transition of students in foster care from one school district to another when such a transfer is in the child's best interest. The policy will assure critical elements such as transportation to school, timely record transfer, credit transfers, and special education services with timely Individual Educational Plans (IEPs) are addressed (Reference the Coordination with Fostering Connections to Success and Increased Adoption Act of 2008 section).
- By October 2010, develop partnerships with local land banks to provide housing for foster care youth who may have the skill level to make repairs and bring the house up to code. Collaborate with other agencies and businesses to assist youth in learning the necessary skills to rehabilitate housing.
- By October 2010, collaborate with three urban schools and child welfare stakeholders to develop three jointly funded positions for in-school educational planners that work with foster youth.
- By October 2010, develop partnerships within the five urban counties (Wayne, Kent, Genesee, Oakland, and Macomb) to create affordable and safe housing for former and transitioning foster youth, while addressing youth housing barriers due to age and stereotypes associated with the young adult population.
- By December 2010, coordinate with the Bureau of Juvenile Justice (BJJ) to ensure those youth who are eligible for Chafee funds are aware of and have access to applying for the funds.
- By October 2012, DHS will collaborate with MDE, DCH, Community Mental Health, special needs youth, and MRS to identify best practices and generate recommendations on developing and implementing policy and supportive placements outside of the adult foster care system.

Measurement:

- Youth in Transition Policy will be published by January 1, 2010 that includes Juvenile Justice youth as an eligible population.
- By August 1, 2010, implement a foster youth friendly policy for local schools surrounding the special needs for youth in foster care.
- By September 30, 2010, baseline data will be gathered on the number of foster youth ages 14-20 in foster care and transitioned from foster care, who are parents, have been pregnant, or are pregnant.
- By October 1, 2010, DHS and MSHDA will submit a joint grant application for 100 housing choice vouchers.
- By October 1, 2010, at least one urban county will have youth transitioning from foster care learning how to rehabilitate homes.
- By October 1, 2010, three educational planners will be jointly funded by the DHS and the MDE.

- By October 1, 2011, a minimum of two urban counties will have safe, affordable housing programs for youth transitioning from foster care, guardianship, or who were adopted after age 16.
- By October 1, 2011, the AmeriCorps VISTA Volunteers will have met the objectives of developing a mentor program, increasing the number of community partners, ensuring community resources support housing attainment and maintenance, and developed community service opportunities for youth.
- By October 1, 2012, policy and services will be in place to ensure youth with special needs are provided services to ensure they can live up to their full potential and supportive placements outside of the adult foster care system are in place.
- By September 30, 2014, teen pregnancy will be reduced 20% among foster youth, adopted youth, youth in guardianships, or former foster youth ages 14-20.
- By October 1, 2014, all five urban counties will have safe, affordable housing programs for youth transitioning from foster care, guardianship, or who were adopted after age 16.

Goal: Establish a foster care trust fund program for youth receiving independent living services for transition assistance.

Objective:

- By October 1, 2012, develop a legislative alliance to ensure at least one youth transitioned from foster care is a member of the state foster care advisory board administering the fund.

House Bill 6089 (2008) Public Act 525 of 2008 (Effective: 1/13/2009) – Foster Care Trust Fund Act and House Bill 6090 (2008) amends the Michigan Income Tax Act to permit an individual to designate a contribution to the Foster Care Trust Fund on their annual Michigan income tax. This bill also:

- Established the Foster Care Trust Fund to oversee the development or operation of a public or private nonprofit foster care program, if the organization can match 50 percent of the amount received.
- Created a state foster care advisory board to administer the Fund and disburse money according to criteria developed by the board.
- Prohibited any money from being spent from the Fund until the amount donated to it met or exceeded $800,000.
- Required the advisory board to prepare an annual accounting of revenue and expenditures from the Fund and provide it to the legislature.
- Required the advisory board to work collaboratively with private and public foster care programs to identify and address the problems facing children in the foster care system, work to raise awareness of foster care and develop a support network for youth aging out of foster care.

Measurement:

- By September 30, 2014, at least one former foster youth shall be a member of the State Foster Care Advisory Board.

Coordination with Native American Tribes

Goal: The DHS Youth Services Unit will improve the relationship with Michigan's Indian Tribes specifically related to determining eligibility for benefits and services and ensuring fair and equitable treatment for Indian youth in care.

Following is a description of how each Indian Tribe in the State has been informed of the programs to be carried out under the CFCIP:
DHS holds Quarterly Tribal State Partnership meetings with representatives from Michigan's twelve federally recognized Tribes, tribal organizations, local county DHS, central office and CWTI staffs. Information on CFCIP has been provided to the federally Tribes in Michigan during the partnership meetings. The Youth Services YIT/ETV Analyst will re-establish the relationship with Michigan's Tribal partners by October 1, 2010 to ensure the federally recognized Tribes in Michigan have access to CFCIP.

Goal: The DHS Youth Services Unit and each individual federally recognized Tribe in Michigan will agree on a definition of Tribal consultation.

Objective:

- By October 1, 2010, DHS will have in writing the definition and method for consultation with federally recognized Tribes in Michigan.
- By October 1, 2010, the DHS Youth Services Unit will ensure that each individual federally recognized Tribe in Michigan will contribute to discussion and changes in policy for YIT and ETV funding, contracting and service opportunities, and ICWA compliance (Reference the Coordination with Tribes: Office of Native American Affairs section).

Measurement:

- By January 1, 2011, the definition for Tribal consultation will be included in the DHS foster care manual under sections titled The Youth In Transition (YIT) Program (FOM 950) and Educational Training Voucher (ETV) Program (FOM 960).
- By January 1, 2011, changes to the DHS foster care manual under sections titled The Youth in Transition (YIT) Program (FOM 950) and Educational Training Voucher (ETV) Program (FOM 960) will include recommended changes to policy and practice based on consultation by Michigan's federally recognized Tribes.

Goal: The DHS Youth Services Unit will work with each individual federally recognized Tribe in Michigan to ensure that the youth needs of Michigan's Tribal partners are being met.

Objective:

- Improve the access for Michigan's federally recognized Tribal youth to ETV's and YIT funds by April 1, 2010.

Measurement:

- The implementation of the YIT module in SWSS FAJ by October 1, 2009 will track data on the number of federally recognized Tribal youth receiving Chafee funds and ETVs in comparison to non-Tribal youth.

Goal: The DHS Independent Living Coordinator and Youth Services Manager will attend two quarterly Tribal State Partnership meetings each year to ensure Michigan's Tribes are aware of and have input into Chafee and ETV funding.

Objective:

- Ensure during each fiscal year that the DHS Youth Services Unit maintains a collaborative relationship with Michigan's Tribal Partners.
- Ensure during each fiscal year each of Michigan's federally recognized Tribes have regular access to the DHS Youth Services Unit in order to ensure Tribal youth have access to ETV's and YIT funds.

Measurement:

- Documentation of meetings and changes in policy and practice will reflect an ongoing collaboration, tribal consultation, and changes in the DHS foster care manual under sections titled The Youth In Transition (YIT) Program (FOM 950) and Educational Training Voucher (ETV) Program (FOM 960).

Describe the efforts to coordinate the programs with such Tribes.
Meetings with the Director of Native American Affairs, the federally recognized Tribes in Michigan, and the DHS Independent Living Coordinator occurred in August of 2006 and 2007. During those meetings, the DHS Independent Living Coordinator provided information and developed a mechanism for Tribal Partners to access the ETVs. By January 2010, the Youth Services unit will reconnect with federally recognized Tribes in Michigan to ensure Tribal partners are aware of and know how to access the YIT funds and ETVs.

The DHS ETV and YIT Coordinator will continue to collaborate with the DHS Director of Native American Affairs to obtain input from Michigan's Tribal partners, update written procedures, and ensure that tribal youth have access to YIT and ETV funding and services when needed.

Discuss how the state ensures that benefits and services under the programs are made available to Indian children in the state on the same basis as to other children in the state.

Objectives:
The DHS Youth Services Unit will by October 1, 2010:

- Meet with each federally recognized Tribe to ensure Tribal Social Services Directors have the appropriate information on how to access YIT funds and ETVs for tribal youth.

- Distribute information on eligibility and accessing YIT funds and ETVs to each individual federally recognized Tribe.
- Develop and implement annual surveys with Tribes to identify which federally recognized Tribes in Michigan need additional information to access ETV and YIT funds.
- Collaborate with the Native American Affairs Director to provide training and technical assistance for federally recognized Tribes in Michigan to access ETVs and YIT funding.
- Revise the DHS-4713, Youth Service Profile Report and work with the DHS Data Management and Quality Assurance units to ensure data collection identifies the youth's federally recognized Tribal membership (Reference the DHS Data Management section for additional information).

Measurements:

- Surveys will be executed and evaluated annually to identify gaps in knowledge and understanding accessing and using the ETVs and YIT funds, as well as where to target training.
- The DHS 4713 Youth Service Profile Report will be operational on SWSS and include federally recognized Tribal membership for data collection.
- The implementation of the YIT module in SWSS FAJ by October 1, 2009 will track data on the number of federally recognized Tribal youth receiving Chafee funds and ETV's in comparison to non-Tribal youth.

Report the CFCIP benefits and services currently available and provided for Indian children and youth in fulfillment of this section and the purposes of the law.

All Chafee benefits and services are available to Michigan's federally recognized Indian Children that meet the criteria set for foster care youth.

Goal: Include Tribal representatives and Tribal youth in the DHS Youth in Transition policy development, changes and updates annually beginning in January 2010.

Objectives:

- Ensure policy development for Youth in Transition funded services includes Michigan's Tribal partnership input.

Measurement:

- Documentation of meetings with the federally recognized Tribes in Michigan will identify Tribal partnership involvement in policy development.

Describe whether the State has negotiated in good faith with any Tribe that requested to develop an agreement to administer or supervise the CFCIP or an ETV program with respect to eligible Indian children and to receive an appropriate portion of the State's allotment for such administration or supervision. Describe the outcome of that negotiation.

To date, no Tribe has requested an agreement to administer the CFCIP or ETV program. Enhanced collaboration and provision of any requested technical assistance for Tribes to develop such agreements will occur.

Goal: Continue to be available and prepared to negotiate with Michigan's Tribal partners to develop tribal partnerships for ETV or YIT funds and grant administration through FY 2014.

Objective:

- Ensure federally recognized Tribes are eligible to receive an appropriate portion of the of the State's allotment of ETV and Chafee for funding and services to support education and self-sufficiency.

Measurements:

- Policy will reflect the process and procedure for the federally recognized Tribes in Michigan to access the ETVs and Chafee funds for tribal youth. Policy will be developed in consultation with Michigan's federally recognized Tribes.

The Chafee Foster Care Independence Program (CFCIP) Program Purposes:
Help youth transition to self-sufficiency.

Goal: Youth who are 14-21 years old will have the knowledge and tools to be successful adults. This will include independent living skills as well as social, relational, and community engagement skills.

Objective: To meet the needs of older youth, DHS Youth Services Unit will:

- By January 2010, through the continued monitoring of Homeless Youth and Runaway contractors via monthly reports, quarterly group meetings, and annual site visits, 25 percent of homeless youth served, ages 16-20, will be former foster youth, or youth homeless as the result of a disrupted adoption or guardianship.
- Assist local DHS offices to continue developing Community Partner Boards (CPBs) and increase the number of CPBs by 20 new boards across the State of Michigan by September 30, 2014. CPBs are committed to improving outcomes for youth in or exiting from foster care.
- Assist local DHS offices to continue developing alliances with local business, non-profit and government agencies to support resources, provide free or discounted services, and advocate for systems change for the young adult foster youth population. Free or reduced services to youth aging out will increase 20% by September 30, 2014.

Measurements:

- Baseline data of the number of community partner boards will be collected by October 31, 2009.
- Annual measurements beginning in October 2010 will indicate the number of community partner boards established. This data will be reported annually in the APSR.

- Baseline data of the number of free or reduced services available to youth in the 30 MYOI counties will be collected by October 31, 2009.
- Monthly and annual coordinator reports from the local DHS offices implementing MYOI and the YSDM will be provided to Youth Services.
- Beginning in October 2009, documentation by Homeless Youth and Runaway contractors will be provided monthly and annually to the DHS Contract Administrator in Youth Services and will include the number of total youth served in Transitional Living Placements (TLP), the number of youth meeting the foster care, adopted, guardianship criteria, and any barriers to providing those services.
- Annual site visits will be conducted by the DHS Contract Administrator. A summary of these findings and compliance with expectations and data on foster, adopted, or guardianship youth will be included in the annual APSR.

Goal: Help youth receive the education, training and services necessary to obtain employment.

Objectives: To ensure that foster youth are receiving adequate education, training and services, the DHS Youth Services Unit will:

- During FY 2010, continue to support a Foster Care Youth Demonstration Project to assist foster youth obtain their high school diploma or GED and provide employment skills in the largest urban county in the state. Youth served are ages 17 to 21.
- Beginning in FY 2010, access staff from the Foster Care Youth Demonstration project to provide technical assistance to Michigan Works! Agencies (MW!A's) on best practices for working with youth in foster care, transitioned from foster care, and youth who were adopted or placed in a guardianship after age 16.
- Continue to collaborate with the Department of Energy, Labor and Economic Growth (DELEG) to ensure that a minimum of 150 foster youth participate in the Summer Training and Employment Program (STEP) beginning in March 2010. STEP provides paid summer work experience and work-based learning activities integrated with classroom instruction.
- As established in April 2009, continue to ensure that all foster youth age 14 and older without a reunification goal will be referred to Michigan Works! Agencies by their DHS caseworker. The DHS Youth Services Unit staff will work with local Michigan Works! Agencies and DHS offices to make sure the referral process is occurring without difficulties and that youth are receiving services.
- Increase the number of education planners from 2 to 14 by April 1, 2010. Educational planners will provide consultation and support for youth ages 14 and older in accessing educational services. Planners assist with accessing educational services, education and employment goal setting, and supports. The DHS Youth Services Unit will ensure educational planners are trained in special needs, Free Application for Federal Student Aid (FAFSA), Individual Educational Plans (IEPs), McKinney-Vento, and youth advocacy.
- By October 1, 2011, initiate Independent Living contracts to ensure the provision of Chafee funds for services related to employment and training throughout Michigan will be consistent and maximize access for all eligible youth.

- Through FY 2014, continue collaboration with the Michigan Department of Treasury, Partnership for Learning, Wayne State University and University of Michigan to expand the project of Foster Care College Goal Saturday. The annual event assists high school seniors in foster care to complete their financial aid applications for college.

Measurements:

- By September 15, 2009, the DHS Youth Services Unit will request assistance from the DHS Data Management Unit (DMU) and the Department of Information Technology (DIT) to collect date through SWSS/FAJ on the number of youth 14 and older in foster care who are referred to MW!A's. The target date for implementing this system is April 1, 2010.
- Beginning October 1, 2009, quarterly outcome data on the number of youth served, employed, completing high school or a GED, participating in life skills classes, and remaining crime free are recorded and reported to DHS Youth Services by the Foster Youth Demonstration project.
- Data will be provided annually by the DELEG to the DHS Youth Services Unit by September 30th on the location and number of youth involved in the STEP program. The first data report will begin on September 30, 2010.
- Fourteen Educational Planners will be trained by December 31, 2009. Training will be documented through the Child Welfare Training Institute (CWTI) website.
- Data on all Chafee funded services will be reported in SWSS/FAJ monthly and collected quarterly beginning October 1, 2009. This will include the number of youth served and the specific types of assistance received that is Chafee funded.
- Documentation of the number and location of College Goal Saturdays (educational outreach programs) will expand from one to three sites by October 1, 2012 and be included in the APSR.

Goal: To train DHS and private child welfare staff in issues that impact foster youth.

Objective: The Youth Services Education/Employment Analyst will provide training and/or presentations a minimum of five times per year beginning in FY 2010 to DHS, private CPA staffs, and foster parents. The training will include:

- The purpose of the DHS-945, Financial Aid Verification Form Tips, including the information that this form serves as proof that a student was in foster care at some time after their 13th birthday and qualifies as an independent student.
- Information on the actions that caseworkers can take with youth who are at the middle/high school levels to ensure they complete their high school diploma or GED.
- Information on how to advocate for youth to ensure their educational needs is addressed.
- Policy changes regarding education and employment services.
- Training on the new MW!A policy and the referral form, along with information on overcoming the barriers for youth receiving MW!A services.
- Summer employment opportunities.

Measurements:

- By October 2010, all Wayne County MW!As will be trained on how to assist foster youth transitioning from care. Training will be documented through the CWTI website.
- Changes in Education and Employment policy will be published by January 1, 2010.
- By September 30 of each year beginning in FY 2010, a minimum of five trainings per year will be conducted on ensuring middle/high school youth complete high school. Training will be documented through the CWTI website.
- Data will be provided annually by the DELEG to the DHS Youth Services unit by September 30 on the location and number of youth involved in the STEP program. The first data report will begin on September 30, 2010.

Goal: Assist youth in preparing for and entering postsecondary training and educational institutions.

Objective: DHS will increase the number of colleges, universities and community colleges that advocate for and provide support for foster youth as well as offer scholarship opportunities for foster youth entering postsecondary education.

- Michigan currently has four universities that offer scholarships and/or assistance to former foster care youth.
- The Youth Services Unit staff will participate in the Michigan College Access Network (MCAN), a one-stop Web site for students to plan, apply and pay for college. This Web site is scheduled to be implemented in the fall of 2010. As a participant in the network, DHS Youth Services staff will ensure that resources for foster youth are included on the Web site.

Measurement:
Michigan will add one post-secondary institution offering a foster care scholarship opportunity each year for the next 5 years.

Goal: Provide personal and emotional support to youth through mentors and the promotion of interactions with dedicated adults.

Objectives: DHS will implement the Youth Service Delivery model throughout Michigan over the next five years, which includes significant adults willing to support the youth in attaining permanency.

- Collaborations with Mentor Michigan and Americorps beginning October 1, 2009 will provide mentoring services and resources to foster youth 14 and older who remain in care, youth who have aged out of foster care, and youth who were adopted or placed in guardianships after age 16 but who have not reached the age of 21.

- Mentor training will be developed and completed for AmeriCorps VISTA volunteers and local DHS staff. The training will include information on developing mentor programs, recruiting, training, and monitoring mentors.
- Develop and maintain a resource guide on the FYIT Web site to assist youth in accessing information on how to request a mentor.

Measurements:

- By December 1, 2009, mentor training will be developed and completed for AmeriCorps VISTA volunteers and local DHS staff.
- By September 30, 2010, three trainings per AmeriCorps VISTA site will be completed.
- By October 1, 2010, a resource guide will be available on the FYIT website.
- By May 1, 2010, the information guide for mentors will be completed and distributed.
- By October 1, 2010, 20 foster care youth will have established a mentor relationship or have an identified supportive adult.

Goal: Provide financial, housing, counseling, employment, education, and other appropriate support and services to former foster care recipients between 18 and 21 years of age.

Objectives: To ensure the provision of services to former foster care youth, DHS will:

- Educate DHS and private CPA staff on Foster Care Transitional Medicaid (FCTMA), including information that youth aging out of foster care and receiving Medicaid managed care can receive annually up to 20 hours of mental health services. Trainings will be provided six times per year beginning October 1, 2009.
- Ensure that the Foster Care Transitional Medicaid coverage for former foster youth ages 18-20 (implemented in May 2008) is fully utilized by conducting mass mailings of the FCTMA Brochure to youth who aged out of care beginning May 2008.
- Conduct an annual workshop for youth that consists of all services and resources available to them including the information that can be accessed at the FYIT website during the Michigan Teen Conference convened at Central Michigan University each June.
- Develop collaborative relationships with dental health colleges and dentists who will provide free or lower cost dental services to youth aging-out of foster care. This need will be conveyed during two trainings and presentations to Michigan Dental Schools each year beginning October 1, 2009.

Measurements:

- Register and track the number of public and private agency CPA training participants. Training will be documented through the CWTI website.
- Collaborate with the DMU to obtain quarterly data reports beginning with the first quarter of FY 2010 on the number of youth receiving FCTMA and the number of youth eligible for FCTMA.

- Data on all Chafee funded services will be reported in SWSS/FAJ monthly and collected quarterly beginning October 1, 2009, which includes the number of youth served and the specific types of assistance received that is Chafee funded
- Document the number of providers offering dental services to former foster youth as a result of the trainings and presentations offered.

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Goal: Ensure Education and Training Vouchers (ETVs) are available to youth who have aged out of foster care.

Objective: Beginning October 1, 2009 and continuing until September 30, 2014, the DHS will:

- Ensure all youth who have aged out of the foster care system, and youth who were adopted or placed in a guardianship after age 16 have access to ETVs.
- Continue to ensure the ETV Program is administered through a DHS contract and that the contractor maintains a database and Web site (www.mietv.lssm.org) that streamlines the application process.
- Annually, the DHS ETV Contract Administrator will conduct site visits and review files to ensure contractor compliance.
- Ensure youth have access to and are able to complete the ETV application online, downloading a paper application or calling a toll-free number to request an application (1-877-660-METV).
- Continue to ensure that ETV disbursements are sent directly to the postsecondary institutions, vendors, or in some instances, the youth. The contractor provides all of the necessary services to assist a youth in completing an ETV application.
- The contractor will continue to expand services to youth by developing collaborative relationships with community partners such as state agencies, postsecondary institutions and private CPAs.

Measurements:

- The contractor will collect data that includes the number of youth applying and awarded ETV's, the number of years each youth obtains an ETV, and the number of youth who successfully complete their post-secondary education or training program. This data is provided annually to DHS by the contractor.

Goal: DHS will increase the number of youth who hold Individual Development Accounts (IDA's) by 10 percent each year from FY 2010 through FY 2014.

Objective:

- Increase the number of financial literacy trainings provided to youth who are YIT eligible which include budgeting, how to open and maintain a checking and savings account, investing, how to recognize financial scams, responsible credit use, and setting and achieving savings goals.
- Transition youth currently holding one personal savings account and one IDA to holding one IDA savings account and one checking account by January 2011.

Measurements:

- Baseline data on current IDA holders will be collected in September 2009.
- By October 15 of the close of each fiscal year, 2010-2014, annual data collection identifying the number of IDAs established each fiscal year, the amount of accumulated deposits to youth's IDAs, and, if available, the amount of matching funds awarded for specific asset purchases will be recorded and reported.

Goal: The DHS Youth Services Unit staff will develop alliances with business, non-profit and government agencies to increase support resources, provide free or discounted services and advocate for systems change for the young adult foster youth population.

Objectives:

- During FYs 2010-2014, conduct quarterly presentations to local business, non-profit and government agencies and private CPA staff on youth needs and the best practices for meeting those needs.

Measurements:

- Record and report annually the number of presentations, location of presentations, and any system changes implemented as a result of the outreach efforts.

Goal: Ensure youth have opportunities for safe and stable housing as well as the supportive services to help them attain housing and remain in the housing.

Objectives: The DHS Youth Services Unit will:

- Collaborate with the MSHDA to expand the program for youth aged 18-24 that provides assistance and supportive services over a two-year period beyond the five counties of Wayne, Kalamazoo, Saginaw, Lenawee, and Grand Traverse that currently provide these services.
- Conduct meetings with local housing commissions to develop partnerships and community opportunities to assure affordable and safe housing for former and transitioning foster youth is available. Address youth housing barriers based on age and stereotypes associated with the young adult population. Over the next five years, a minimum of five counties with the highest youth population will develop local protocols for establishing safe, affordable housing, and supportive resources for youth who have transitioned from foster care.
- Develop partnerships with local land banks to provide housing for foster care youth who may have the skill level to make repairs and bring the housing up to code. Collaborate with other agencies and businesses to assist youth in learning the necessary skills to rehabilitate housing.

Measurements:

- By October 1, 2010, at least one urban county will have youth transitioning from foster care learning how to rehabilitate homes.

- By October 1, 2011, a minimum of two urban counties will have safe, affordable housing programs for youth transitioning from foster care, guardianship, or who were adopted after age 16.
- By October 1, 2014, all five urban counties will have safe, affordable housing programs for youth transitioning from foster care, guardianship, or who were adopted after age 16.
- By September 30, 2014, the DHS and the MSHDA will expand housing options for youth ages 18-24 in three previously unfunded counties.

Goal: The DHS Youth Services Unit will establish and develop programs and services for foster care youth age 14 -20, foster youth that have transitioned from care, and youth placed in guardianship or adoption after age 16. Information on programs and services will be disseminated statewide.

Objective:

- The Youth Services Unit staff will market the FYIT Web site enhancements beginning October 1, 2009 at the annual Michigan Teen Conference and during bi-weekly telephone conferences with staff assigned to serve older youth in foster care and youth transitioned from foster care.
- By September 30, 2010, the FYIT website will include:
    - Local county contact information for YIT funding, MYOI, and the Youth Service Delivery Model.
    - Local information on the YSDM expansion process.
- By FY 2013, the DHS Youth Services Unit staff will implement Web-based training:
    - For youth on how to complete a FAFSA.
    - For child welfare workers on how to complete the Medical Passport.

Measurements:

- Baseline data on the number of visits to the FYIT website will be gathered by October 15, 2009.
- Beginning on January 1, 2010, quarterly data will be tracked on how many page views occur of the FYIT website.
- By October 15, 2013, data will be gathered through the CWTI website annually to track the number of youth and staff accessing the web-based training.

Goal: Provide services to youth who, after attaining 16 years of age, who have left foster care for kinship guardianship or adoption.

Objective: To ensure continuing services to youth who have left the foster care system to a guardianship or adoption, DHS will:

- Develop and implement policy that includes the requirements that older youth have access to independent living and ETV services beginning October 1, 2009.
- Beginning October 1, 2009, communicate policy updates to DHS and private CPA staffs and eligible youth through presentations, list serves, Michigan's Foster Youth In Transition Web site, Youth Boards and conference calls.

Measurement:

- Review the demographic data collected in SWSS/FAJ for those youth accessing YIT funded services as reported on the DHS-4713, Youth Service Profile to identify the number of youth in this population in FY 2010. FY 2010 will be a baseline year for collecting data and monitoring services provided to this population

Goal: DHS will ensure youth under the age of 16 in foster care are provided the necessary services to achieve self-sufficiency and independence.

Objectives: (Please refer to the Description of Program Design and Delivery pp. 120-125.)

- Fully implement the Youth Service Delivery Model statewide by September 30, 2014.
- Implement a state level team to reduce pregnancy for foster youth by November 1, 2009.
- By November 1, 2009, fifteen (15) AmeriCorps VISTA Volunteers will be selected to develop mentoring programs, increase the number of community partners actively supporting youth, and develop community service opportunities for youth.
- Coordinate with the Bureau of Juvenile Justice to ensure eligible youth have access to Chafee funded services including policy changes by January 1, 2010.
- Collaborate with the Michigan Department of Education (MDE) to improve the transition of students in foster care from one school district to another when such a transfer is in the child's best interest. Policy development will assure critical elements such as transportation to school, efficient record transfer, credit transfers, and special education services with timely Individual Educational Plans (IEPs) are addressed. (Reference the Coordination with Fostering Connections to Success and Increased Adoption Act of 2008 sections).
- Collaborate with three urban schools and private and public stakeholders to develop three jointly funded positions for in-school educational planners that work with foster youth.
- Develop and implement dynamic youth boards that meet monthly in each urban or non-dual county, dual-county cluster, or regionally based geographic area.

Measurements:

Please refer to earlier sections within the Description of Program Design and Delivery for specific measurements for the objectives noted above.

Goal: DHS will ensure youth ages 16 to 18 who remain in foster care or are in the process of transitioning from foster care are provided the necessary services to achieve self-sufficiency and independence.

Objectives: (Please refer to the Description of Program Design and Delivery pp. 120-131.) In addition to the services listed for youth under age 16, the following supports will be provided:

- Continue youth involvement through Youth Boards, Michigan Youth Opportunities Initiative (MYOI), youth participation in statewide committees and input on the Youth Service Delivery Model and legislative presentations.
- Develop and implement the Youth State Advisory Committee (YSAC) to make recommendations for systemic changes, identify the outcomes for the desired changes, and support the implementation of system changes.
- Develop and implement dynamic youth boards that meet monthly in each urban, dual-county cluster, or regionally based geographic area.
- Develop and implement an executive team of youth trained in communication, media, leadership and advocacy skills for each Youth Board.
- Support and develop an annual *Youth Voice* publication to identify youth priorities for practice and policy development.
- Support and develop a web-based youth networking capacity for youth boards as well as to facilitate individual youth communication.
- Provide technical assistance and encourage each county, dual-county or region with a youth board to develop a monthly youth-driven newsletter or ensure access to neighboring county's youth newsletter.

Measurements:
Please refer to earlier sections within the Description of Program Design and Delivery for specific measurements for the objectives noted above.

Goal: DHS will ensure youth ages 18 to 20 who remain in foster care or are in the process of transitioning from foster care are provided the necessary services to achieve self-sufficiency and independence. This population includes youth who left foster care after age 16 to attain permanency through adoption or guardianship.

Objectives: (Please refer to the Description of Program Design and Delivery pp. 120-131). In addition to the services listed for youth ages 16 to 18, the following supports will be provided:

- Youth will continue to be provided information and access to Chafee funded services through the FYIT website and local DHS offices.
- Youth will continue to be provided information and access to ETVs through the FYIT website and local DHS offices.
- By October 1, 2010, collaborate with the Department of Community Health (DCH), MDE, Michigan Rehabilitation Services (MRS), and DHS and private CPA staffs to ensure youth with mental health challenges and/or disability issues will transition from children's foster care into stable, supportive living environments

that encourage and provide life skills that will help them acclimate to their environment and promote self-sufficiency.

- Collaborate at the state level with Community Mental Health (CMH) staff to conduct trainings for DHS and private CPA staffs on special needs youth at a minimum of one time per year beginning October 1, 2010.
- By January 1, 2011, develop protocols for public, private and state level agencies to implement training for DHS and private CPA staffs, biological, adoptive and foster parents, and youth on the available resources and funding to serve youth with special needs including educational, developmental, and emotional challenges.
- By April 2011, foster care caseworkers will develop and implement transition plans for special needs youth that require specific steps to ensure that youth have the services and skills necessary to reach their full potential.
- By April 30, 2011, develop policy that will ensure a comprehensive evaluation of a youth's ability to be self-sufficient is conducted prior to placing any 18 year old who with mentally illness or disability in an adult foster care or group home.
- By October 1, 2012, DHS will collaborate with MDE, DCH, CMH, special needs youth, and MRS to identify best practices and generate recommendations on developing and implementing policy and supportive placements outside of the adult foster care system.

Measurements:

- Beginning October 1, 2009, DHS will collect data quarterly on the number of youth and types of services provided by Chafee funds.
- Ongoing annual data collection by the ETV contractor, Lutheran Social Services of Michigan, will include the number of youth receiving ETVs, the number of years youth received ETV's, and the number of youth successfully completing post-secondary education.

For additional measurements, please refer to earlier sections within the Description of Program Design and Delivery for specific measurements for the objectives noted above.

Goal: DHS will ensure that youth with special circumstances such as youth who identify themselves as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) will be provided services to support their transition to adulthood.

Objectives:

- Conduct LGBTQ trainings to DHS and CPA staffs, biological and foster parents, community partner boards, and youth. Annual trainings will occur for youth, Community Partner Boards, staff, foster parents and biological parents.
- Provide LGBTQ links to resources on the DHS FYIT Web site by 2010.

Measurements:

- By October 1, 2010:

- All training for LGBTQ for DHS and private CPA staffs will be monitored and recorded through the CWTI website. Annual report summaries will be included in the APSR.
- All training for youth and community partners will be logged on an Access database application and summarized in the yearly APSR.
- All training for foster parents and biological parents will be logged on an Access database application and summarized in the yearly APSR.

Describe steps taken to prepare and implement the National Youth in Transition Database (NYTD).

Please see section entitled DHS Data Management Unit.

Juvenile Justice Transfers

Please add where the data on Juvenile Justice Transfers was obtained from.
The data was obtained from the DHS Data Warehouse.

Interstate Compact on the Placement of Children

States are asked to provide the frequency with which the state needed the extended 75-day period, the reasons why extensions were needed, extent to which the extended compliance period resolved circumstances and steps states took to resolve need for extensions. I'm not sure what MI is reporting for the 75 day information states are required to report on.

Michigan's completion of interstate home study requests within the 60-day requirement:

- Eighty-five percent (394 of 463) in FY 2007.
- Seventy-nine percent (385 of 485) in FY 2008.

The exception process was only in effect until September 30, 2008. Michigan does not currently have a process in place to request an extension to the 60-day timeframe, or a system to track the reasons that Michigan exceeded the 60-day timeframe.

The Interstate Compact Office regularly follows up with other states to avoid delays in receiving home studies that Michigan has requested. The office runs a daily report of overdue home studies from other states and follows up after sixty days. They continue to follow up every thirty days thereafter until they receive the home study. If necessary, the manager will contact the manager in the other state.

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Adoption Incentive Payments

In fiscal year 2006, Michigan qualified for $192,000 in adoption incentive payments based on the increase in the number of adoptions in 2005. However, the state experienced a severe budgetary deficit that resulted in a spending moratorium. The moratorium prevented the expenditure of state funds even when federal reimbursement was guaranteed. DHS requested that the Department of Health and Human Services, Administration for Children and Families extend the grant funds beyond September 30. 2007, but this is not allowable. Therefore, the state was not able to proceed with the plans to utilize the adoption incentive funds awarded.

Activities for children adopted from other countries
In Michigan, private CPAs handle all international adoptions. They provide adoption and post-adoption services to the families. In addition, all state- and locally-provided family preservation and family reunification services are available to families who adopted internationally and who are at risk for disruption or dissolution.

Additional information
Private agencies that provide services for international adoption are licensed as child placing agencies and are held to Michigan's licensing rules for adoption. The Bureau of Children and Adult Licensing within DHS performs annual onsite reviews and complaint investigations, if there are allegations of a rule violation. As part of the annual onsite licensing review, a sample of cases that may include those where the adoptions have not been finalized in the other country, are reviewed for compliance with the supervision rules. The agency also must meet all of the Michigan licensing rules for staff qualifications, ratios, etc.

Adoption subsidy programs are intended to provide permanency for children with special needs in public foster care. As a result, the statutory requirements for eligibility reflect the needs of children in public child welfare system and are difficult to apply to children who are adopted from abroad. Therefore, although the statute does not categorically exclude these children from participation in adoption subsidy programs, it is highly improbable that children who are adopted abroad by U.S. citizens, or are brought into the U.S. from another country for the purpose of adoption, will meet the eligibility criteria in federal and state law.

The DHS adoption program office is working with the Child Welfare Data Management Division to determine the required elements to track children adopted internationally that enter the system. The tracking will be operational in FY 2010.

STATE OF MICHIGAN - FISCAL YEAR 2007

Family Preservation and Family Support Services Payment Limitations

EXPENDITURES NOT FUNDED BY TITLE IVB SUBPART 2 (1)

Fiscal Data (in thousands) to meet the Supplantation Prohibition

Funding Source	*Family Preservation Services*		*Family Support Services*	
	STATE	*FEDERAL*	*STATE*	*FEDERAL*
Title IV B, subpart 1	$0.0	$0.0	$61.7	$5.3
Title IVA / TANF	$0.0	$67,181.8	$0.0	$4,028.0
Title XX	$0.0	$5,065.2	$0.0	$0.0
Other (please list)				
Direct charged or cost allocated via worker time study to the following Federal funding sources:	$1,380.7	$4,772.5	$0.0	$0.0
IV-E, XIX, Food Stamps, and Child Care & Development Block Grant, Refugee Assistance				
Child Abuse and Neglect Grants	$0.0	$1,084.3	$0.0	$0.0
Community-Based Family Resource	$0.0	$0.0	$0.0	$1,031.0
Program Grant				
Temporary Child Care for	$0.0	$0.0	$0.0	$0.0
Children with Disabilities and				
Crisis Nursery Grants				
100% State Funds	$26,030.2	$0.0	$0.0	$0.0
100% County Funds	$49,999.0	$0.0	$0.0	$0.0
Private Donations	$6.3	$0.0	$2,596.7	$0.0
TOTALS	$77,416.2	$78,103.8	$2,658.4	$5,064.3

(1) The FY2007 Title IVB subpart 2 match requirement (25%) totaled $4,373,836. This requirement was met through State Ward foster care expenditures, which are not included in this report.				
(2) The FY2007 Title IVB subpart 1 match requirement (25%) totaled $3,248,899. The majority of this requirement was met through State Ward foster care expenditures, but also included State spending for prevention, preservation and support services.				
(3) The reduction in state funds expended does not represent supplantation of state general fund by Title IVB P2 funding. TANF was used to fund Title IVB P2 eligible programs. TANF does not have a non supplantation clause and States are encouraged to use TANF for these types of programs.				
(4) Federal and State funding sources, in addition to those specifically identified above, include:				
Federal Community Based Family Services CAPTA grant				
State Children's Trust Fund				
State funded Adult Medical and Assistance programs				
Annie E. Casey Grant				