State of Michigan
Department of Human Services

Special Review of Higher Risk Cases
Period Three: 10/1/09-3/31/10

Child Welfare Improvement Bureau
Quality Assurance

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Preface

The Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare program. The DHS mission includes a commitment to ensure that children and youths served by our public systems are safe, sustain a higher quality of life while enhancing their well-being, and to have permanent and stable family lives.

The DHS Children's Services Administration (CSA) is responsible for planning, directing, and coordinating statewide child welfare programs, including social services provided directly by DHS via statewide local offices and services provided by private child-placing agencies.

On July 3, 2008, Governor Granholm, on behalf of DHS, reached an out-of-court agreement with Children's Rights, Inc. regarding the Dwayne B. v. Granholm, et al. lawsuit. The agreement provides Michigan with a valuable opportunity to reform the existing child welfare system. It builds upon reform efforts already under way and improves safety for children while providing stronger support for those who care for them.

Introduction

The Dwayne B. v. Granholm consent decree requires DHS to develop and implement a statewide Quality Assurance (QA) program, directed by a QA Unit established within the DHS central office. The Child Welfare QA Unit has been established as a division of the Child Welfare Improvement Bureau to ensure the provision of service in accordance with DHS philosophy. The Child Welfare QA Unit's aim is to foster a continuous quality improvement (CQI) culture throughout DHS by introducing CQI concepts to all levels of the child welfare system, training staff on improvement processes and integrating CQI philosophy into long-term and everyday decision making. The QA unit has developed an internal capacity to undertake data collection, verification, and analysis in addition to case record reviews for the higher risk cases identified in the consent decree.

After the submission of the CQI plan in April 2009, the QA Unit began to conduct special reviews as specified by the consent decree. The Data Management Unit (DMU) provides an initial list of identified cases for the high-risk categories. The QA Unit reviews each identified case in the Foster Care Services Worker Support System (SWSS-FAJ) to pre-screen for possible data errors, and ensure that the case meets the cohort definition. The DMU and the QA Unit will continue to refine the querying process to the fullest extent possible.

The QA Unit completed special reviews for Period Three: October 1, 2009 through March 31, 2010. This report is a summary of the findings for the special case reviews conducted for during this period.

Review Process:

The case reads were completed by CQI analysts by reviewing SWSS documentation, actual case files and, if deemed necessary, direct communication with the services worker.

The QA Unit developed a comprehensive case reading tool to conduct the special reviews. The case review process has evolved and will continue to change as we strive to improve the structure of the tool and refine the steps to obtain required information. The tool was developed in April 2009, updated July 2009 and again in October 2009. The current version is in Microsoft Excel and is designed to guide reviewers and capture information relevant to each high risk category. All QA Unit team members, commonly called CQI analysts, contributed to updating the review tool. CQI analysts participated in team meetings, telephone discussions, email communications, and work groups to come to consensus regarding specific questions, suggestions, and protocols.

Prior to conducting a full review, CQI analysts screen the case information on SWSS–FAJ for eligibility. Once eligibility is determined, the analyst completes a full case review which includes reading information contained in SWSS-FAJ (Social Work Contacts and Updated Services Plans/Permanent Ward Services Plans), the physical foster care case file (verification of necessary documentation corresponding to the time frame), Children's Protective Services Investigation Reports (DHS 154) as needed, and the licensing file when appropriate.

Upon completion of a case review, each analyst provides feedback to each local field office and develops a Quality Improvement Plan (QIP) based on the findings. It is then the responsibility of the analyst and the local office to monitor and assess the QIP to ensure that it is addressing the areas needing improvement.

Results: Cohort A

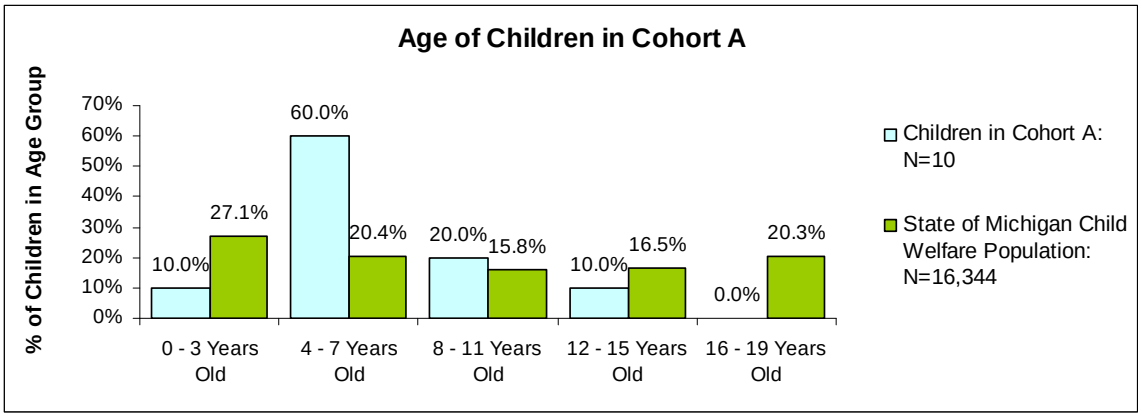
Definition: Children who have been the subject of an allegation of abuse or neglect in a residential care setting or a foster home, whether licensed or unlicensed, between June 2007 and September 2008, and who remain in the facility or home in which the maltreatment is alleged to have occurred.

The QA Unit reviewed 18 cases for this cohort in Report Period Three. As reported in the *Review of Higher Risk Cases: 7/1/09-9/30/09, Maltreatment Cohorts A & B*, published in March 2010, reviews of 18 Cohort A cases were not completed by the end of Report Period Two. These 18 cases were subsequently reviewed in Period Three.

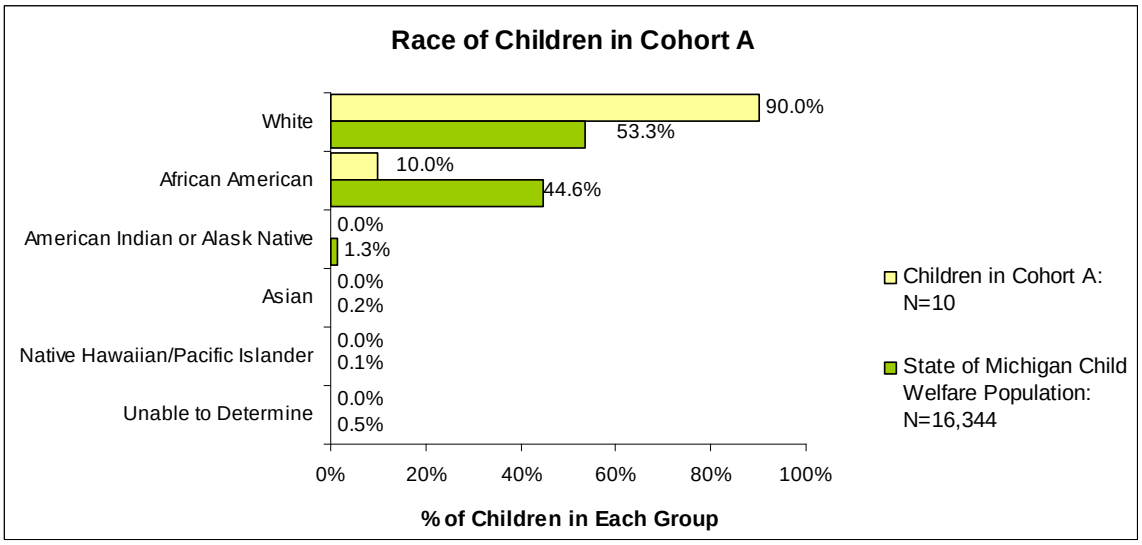
During the pre-screening process, eight cases were determined to not meet the requirements of the high-risk category at the time of review; in three cases the allegation was not against the current placement and five cases were previously reviewed by the QA unit.

Ten cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. Seven of these cases were under the direct responsibility of DHS and three were under the direct responsibility of private child placing agencies.

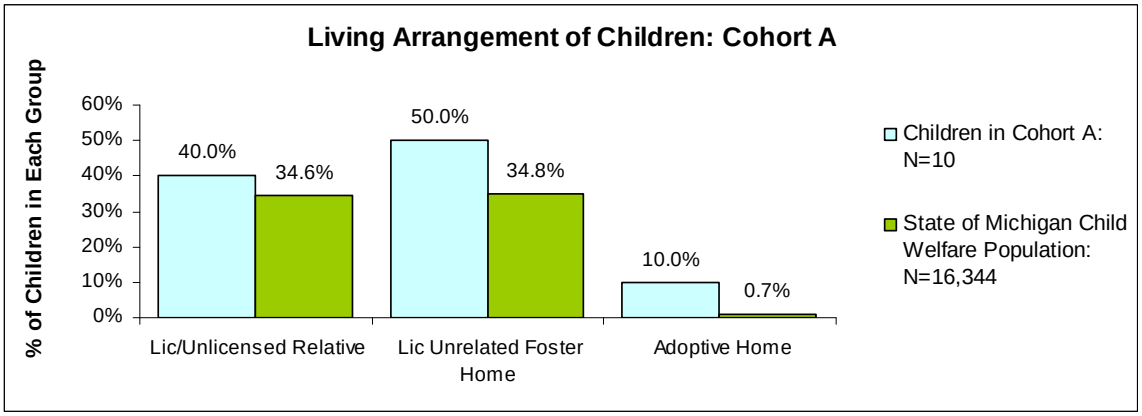
At the time of review, the average age of the children in this group was 9.1 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in Michigan as of 3/31/10.



Nine of the children were white and one was African American. The graph below shows how the cases reviewed compare to Michigan child welfare population.



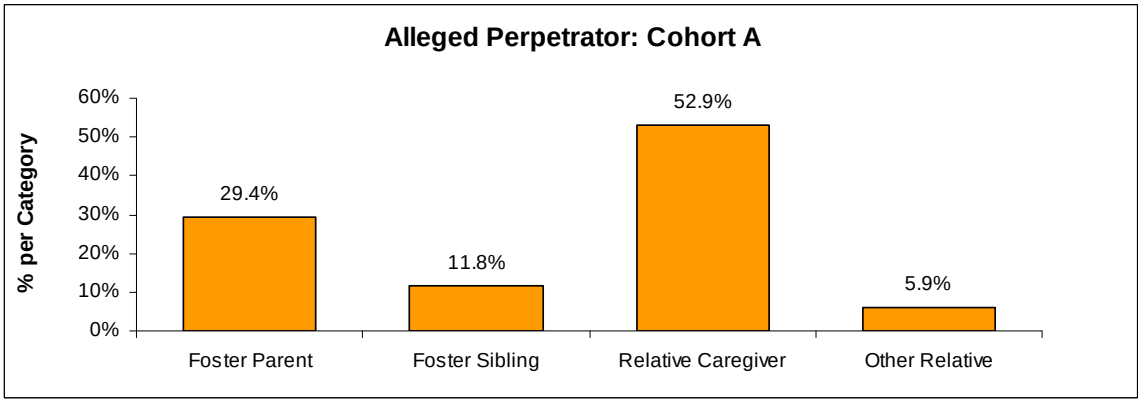
Five children were living in a licensed unrelated foster home, four were living with a licensed/unlicensed relative, and one child was in an adoptive home. The chart below shows the living arrangement of the children reviewed and how they compare to Michigan child welfare population.



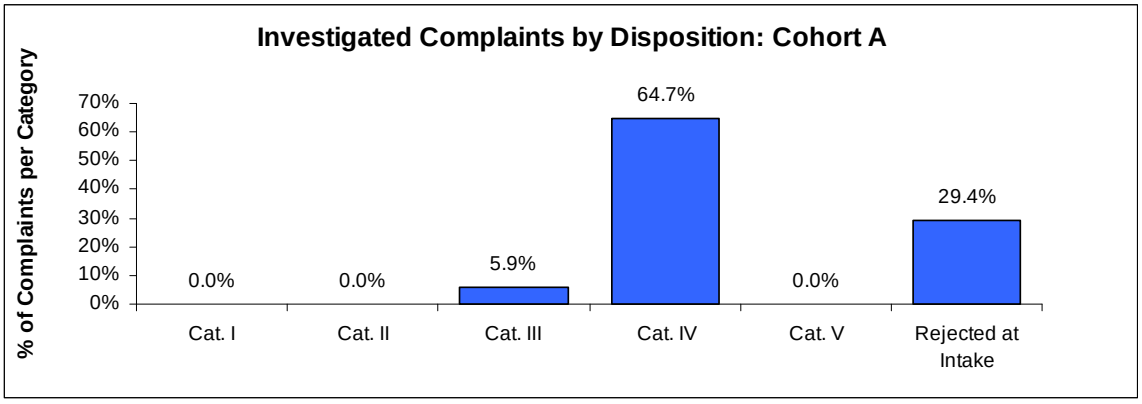
Seven children in this special review category were male and three were female. At the time of review, nine of the children were Michigan Children's Institute wards, one was a temporary court ward, and all ten children had a federal permanency planning goal of adoption.

One case was from Cheboygan County, one from Otsego County, and one from Wayne County. Five cases were from Calhoun County, all from two separate sibling groups. Finally, two cases were from Eaton County and were in the same sibling group.

Seventeen CPS complaints were reviewed for the 10 cases in this cohort. Of those 17 complaints, 10 were categorized as neglect, four as abuse, and three as abuse/neglect. The alleged perpetrator in nine of the complaints was a relative caregiver, five were foster parents, two were foster siblings, and one was listed as another relative. The chart below shows the alleged perpetrator for the reviewed complaints.



The disposition of 11 of the complaints was no preponderance (Cat. IV), one was substantiated (Cat. III), and five were rejected at intake. The chart below demonstrates the disposition pattern of complaints regarding the identified cohort.



Quality Assurance Assessment: Cohort A

Child safety was a critical focus of these reviews. CQI analysts assessed child safety by ensuring that the investigator verified the well being of the alleged victim and all other children in the home, confirmed that the alleged perpetrator was identified and interviewed, and assessed that all possible collateral contacts were made in order to determine the safety of the child.

None of the cases reviewed during this period indicated any immediate safety concerns to the youths and all the findings appeared to reveal specific systemic concerns regarding internal communication and documentation.

The most apparent area of concern was communication and collaboration among the child welfare professionals during the investigation. As in Period Two, there were gaps in communication during the investigations. The CPS investigators did not document necessary communication with the assigned foster care worker and, if applicable, the assigned certification worker. DHS policy mandates the CPS investigator to have contact with the foster care worker and, if applicable, the foster home certification worker during either the preliminary and/or field investigation. It has been found that in most situations the communication is occurring between the workers, but workers are not documenting the contacts consistently. For example, some CPS case files would indicate a contact with the foster care worker, but the foster care case file would not have the same contact documented.

Additionally, of the 17 reviewed investigations, only 3 were documented in the corresponding service plans for that time frame. This too is required by DHS policy and was consistently found as an area of non-compliance in all case reads.

In cases where the alleged perpetrator was a licensed foster parent or resided in a licensed foster home, there was little documentation of contact with Bureau of Child and Adult Licensing (BCAL) workers. In none of the cases was there record of a BCAL special investigation in the CPS or foster care case files.

Recommendations: Cohort A

Review of all the local QIPs shows a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

- DHS policy FOM 722-13, "Foster Care Referrals to CPS."
- DHS policy PSM 716-9, "New CPS Complaints when a Child is in Foster Care," in relation to the CPS investigator forwarding a copy of the DHS-154, within two days of the completion of the investigation, to the foster care worker and certification worker.
- Also under PSM 716-9: The preliminary and/or field investigation initiated by the CPS worker must include contact with the direct foster care worker and if appropriate, the foster home certification worker. Supervisors must ensure that this step has been made before authorizing any disposition of a case.
- QA recommends that local offices implement a plan to ensure compliance with the recent L-Letter and policy ammendments requiring timely input of social work contacts.

Recommendation to BCAL:

- Ensure that the completed special investigation is forwarded to the CPS worker and assigned foster care worker in a timely manner.
- Develop a process to ensure that Special Investigations completed by CPAs are forwarded to the appropriate DHS CPS and foster care case files.

Results: Cohort B

Definition: Children, not in Cohort A, who have been the subject of three or more reports alleging abuse or neglect in a foster home, the most recent of which reports was filed during or after July 2007, and who remain in the foster home in which maltreatment is alleged to have occurred.

The QA Unit reviewed 35 cases for this cohort in Report Period Three. During the pre-screening process, 13 cases did not meet the requirements of the high-risk category at the time of review; seven because the child was no longer in the

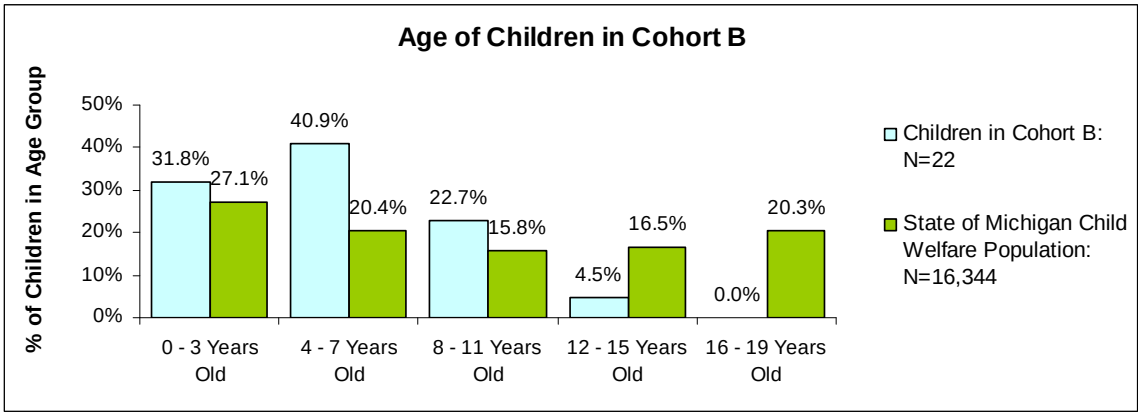
placement where the allegations of maltreatment occurred, three because the allegation was not against current placement, two because the worker incorrectly entered information into the SWSS, and one because the foster care case was closed.

Twenty-two cases received a comprehensive review of SWSS and the physical case files. Ten of the cases were under the direct responsibility of DHS and 12 were under the direct responsibility of private child placing agencies.

The chart below identifies the cases reviewed by county. Please note, the four cases in Grand Traverse County, the two cases in Oakland County, and two in Wayne County were in sibling groups.

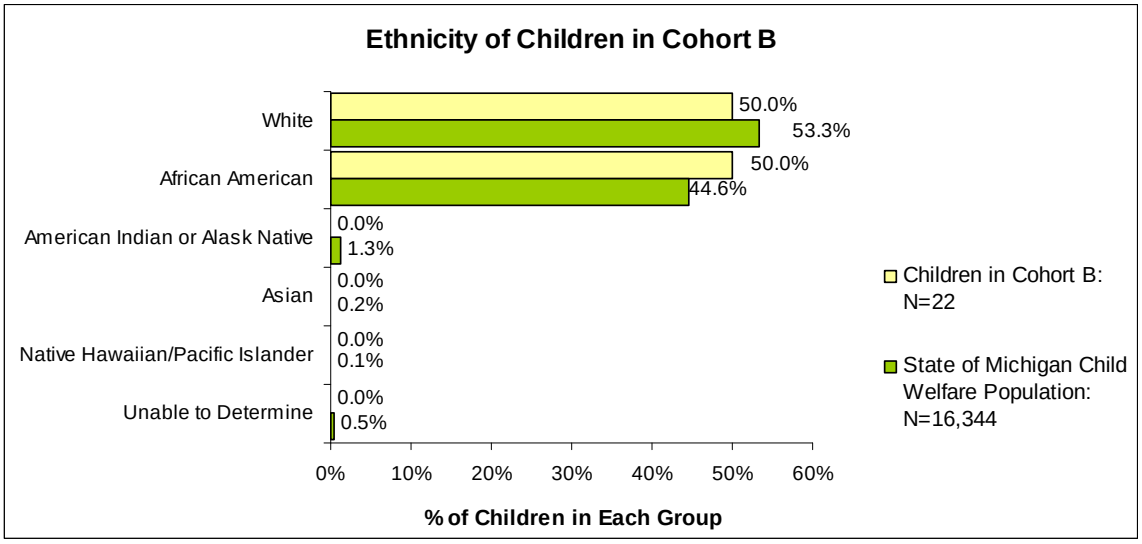
County	Cases per County
Calhoun	1
Clinton	1
Genesee	2
Grand Traverse	4
Jackson	3
Muskegon	1
Oakland	2
Wayne	8

The average age of the children in this group was 5.6 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in Michigan as of 3/31/10.

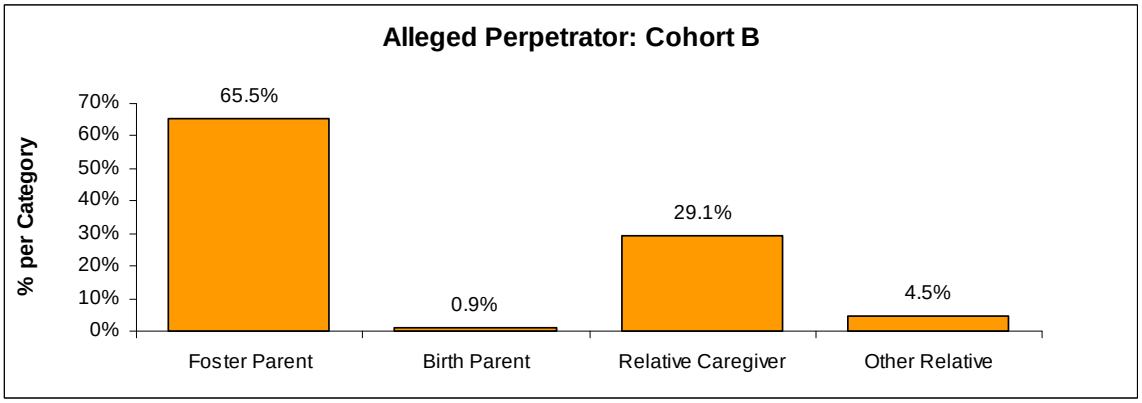


Eleven children were living in a licensed unrelated foster home and 11 were living with a licensed/unlicensed relative. Fourteen children in this special review category were female and eight were male. Thirteen of the children were Michigan Children's Institute wards and nine were temporary court wards. Thirteen children had a federal permanency planning goal of adoption and nine of reunification.

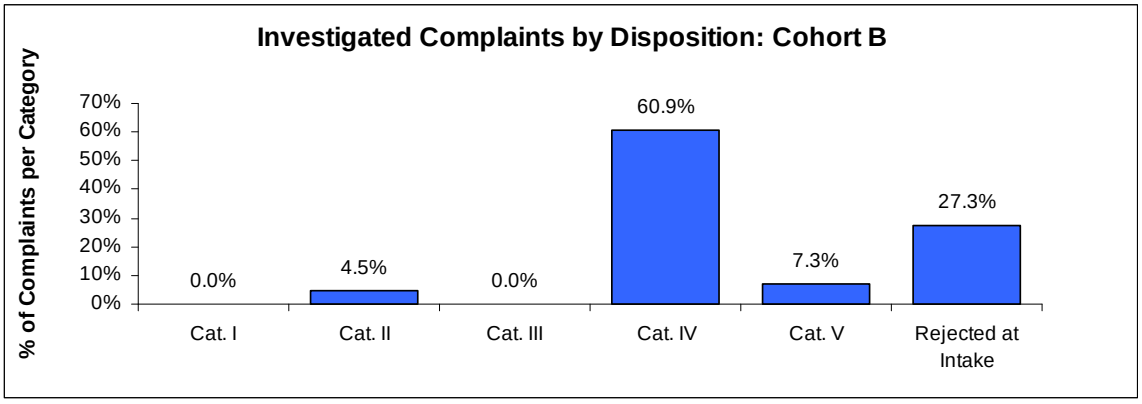
Eleven of the children were white and 11 were African American. The graph below shows how the cases reviewed compare to Michigan child welfare population.



110 CPS complaints were reviewed for the 22 cases in this cohort. Of those, 47 were categorized as neglect, 45 as abuse, and 18 as abuse/neglect. The alleged perpetrator in 72 of the complaints was a foster parent, 32 were relative caregivers, five were listed as other relatives, and one was birth parent. The chart below shows the alleged perpetrator for the complaints reviewed.



The disposition of 67 of the complaints was no preponderance (Cat. IV), eight were denied-no basis (Cat. V), five were substantiated (Cat. II), and 30 were rejected at intake. The chart below demonstrates the disposition pattern of complaints regarding the identified cohort.



Quality Assurance Assessment: Cohort B

Though there are a total of 110 complaints among these 22 cases, many of the cases are companion cases or sibling groups. Breaking down the numbers by *foster home*, there are 110 complaints of CA/N for 14 foster homes. Of those 14 foster homes, the origins of the complaints varied; in Genesee County, where there were eight allegations on one foster home, all eight complaints were reported by the same non-mandated source. Conversely, in Grand Traverse County, nine complaints on one foster home were reported by various mandated sources. In Wayne County, which had the most number of complaints, there were 60 complaints for five foster homes, and the referral sources varied.

Of the 110 statewide complaints (rejected or assigned), 51.8 percent were communicated by mandated reporters.

As in Cohort A, the safety of the child was a critical focus of the Cohort B reviews. Based on the documentation available and reviewed, while there were some identified quality assurance items, at no time during Review Period Three did the analysts identify any imminent safety concerns that demanded immediate attention in order to secure the safety of a child. The analysts in Muskegon, Wayne, Calhoun, and Jackson agreed with the disposition of the investigations, but found procedural problems with the investigations, such as missing face-to-face contacts or other mandatory collateral contacts (mandated source, law enforcement). In Muskegon County the analyst determined that the local office gave the foster parent “the benefit of the doubt” and therefore the CPS complaints were not thoroughly pursued. The analysts in the above-mentioned counties expressed their concerns to local office management in writing.

Other investigations, such as those completed in Grand Traverse, Oakland, and Genesee, were found to be thoroughly conducted and well documented.

For these reviews, the analysts also looked for patterns of investigative error that, if addressed, could have prevented further allegations through services or other interventions. One such pattern noted was a lack of internal communication and documentation among the child welfare professionals during the investigation. As in Period Two, there were gaps in communication during the investigations. The CPS investigators did not document necessary communication with the assigned foster care worker and, if applicable, the assigned certification worker. DHS policy mandates the CPS investigator to have contact with the foster care worker and, if applicable, the foster home certification worker during either the preliminary or field investigation. As stated in Cohort A, there are inconsistencies between the child welfare programs in relation to documentation of internal contacts. One program worker will identify a contact while the other program worker fails to document the same information.

Eighty-three (75%) of the corresponding service plans did not document that a CPS investigation occurred.

In cases where the alleged perpetrator was a licensed foster parent or resided in a licensed foster home, there was little documentation of contact with licensing workers. In some cases there was no record of a BCAL special investigation in the CPS or foster care case files.

Relevant not only to Cohorts A and B, but throughout all the cohorts reviewed, a lack of documentation in the social work contacts section of SWSS-FAJ and SWSS-CPS was a systemic issue. Delayed documentation of face-to-face contact with a child led some analysts to an initial concern for the safety of that child. Only through face-to-face contact with the assigned worker was the analyst able to verify that the child's well-being had been ascertained but that the worker had not yet entered the contact into SWSS. This barrier was found consistently throughout the case reads and led to an abundance of recommendations to respective counties to implement a process to ensure timely documentation of case contacts.

During this report period there was the release of an L-Letter that now mandates DHS direct workers to enter all face-to-face contacts with children, parents, and foster parents/relative caregivers within five calendar days. The L-Letter also mandates DHS private agency foster care monitors to enter all contacts within five calendar days of the receipt of the contact information. CQI analyst will continue to monitor this area and evaluate the compliance with the L-Letter.

This L-Letter is an important first step to proper documentation; however, it does not mandate timely documentation of all collateral contacts nor contacts that are essential to verifying the safety of a child, such as contact with the mandated reporter, school personnel, medical personnel, extended family, Friend of the Court case managers, and internal DHS employees. The children in foster care placements are best served when there is proper case documentation of all contacts with service providers and clear documentation of the conversations conducted regarding that child. The QA Unit recommends that consideration is given to extend DHS policy to include mandated timely documentation of **all** collateral contacts.

Recommendations: Cohort B

As in Cohort A, a review of all the local QIPs shows a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

- DHS policy FOM 722-13, "Foster Care Referrals to CPS."
- DHS policy PSM 716-9, "New CPS Complaints when a Child is in Foster Care." In relation to the CPS investigator forwarding a copy of the DHS-154, within two days of the completion of the investigation, to the foster care worker and certification worker.
- Also under PSM 716-9: The preliminary and/or field investigation initiated by the CPS worker must include contact with the direct foster care worker and, if appropriate, the foster home certification worker. Supervisors must ensure that this step has been made before authorizing any disposition of a case.
- Another significant policy that was noted in noncompliance in Cohort B was PSM 713-10, "CPS History Tab." This policy requires CPS investigators to fully review the family's CPS history in order to assess possible patterns of prior allegations, but more importantly, what types of services were provided to prevent further risk of harm to the youth. It is recommended that this policy is reviewed to ensure staff and managers understand what actions they are to take and specifically what they are to document per policy.
- QA recommends that local offices implement a plan to ensure compliance with the L-Letter and policy ammendments requiring timely input of social work contacts.

Recommendation to Program Office:

- The QA Unit recommends that consideration is given to extend DHS policy to include mandated timely documentation of **all** collateral contacts.

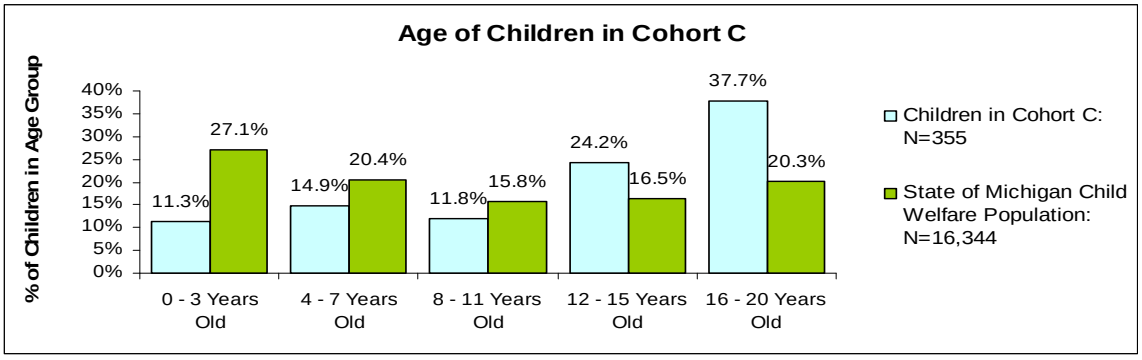
Results: Cohort C

Definition: Children who, at the time of review, have been in three or more placements, excluding return home, within the previous 12 months.

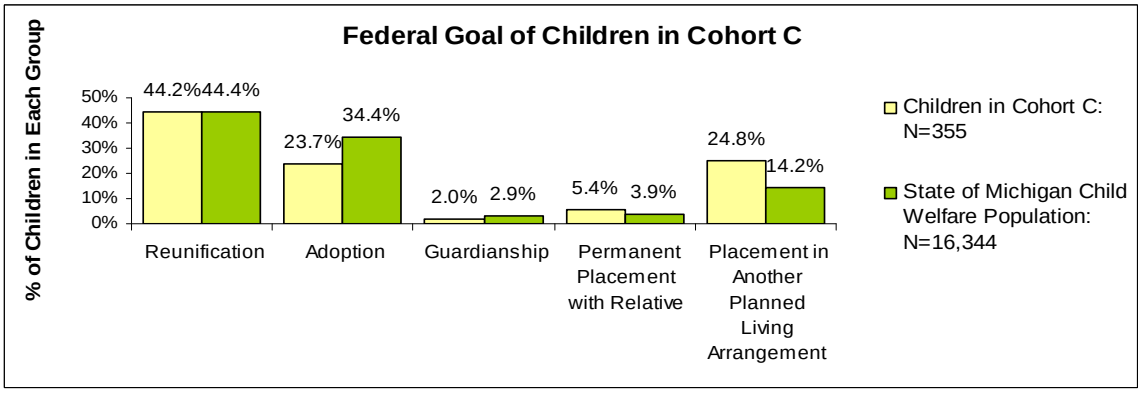
The QA Unit has reviewed 641 cases for this cohort in Report Period Three. During the pre-screening process, 286 cases were determined that they did not meet the requirements of the high-risk category at the time of review. Two hundred and eleven were only in two placements in the past 12 months, 37 were only in one placement, 16 cases were closed, 15 were in their own home, three were reviewed previously, two were juvenile justice cases (not dual wards), and two were adopted.

355 cases received a comprehensive review of SWSS-FAJ and the physical case file. One hundred and fifteen of the cases were under the direct responsibility of DHS and 240 were under the direct responsibility of private child placing agencies.

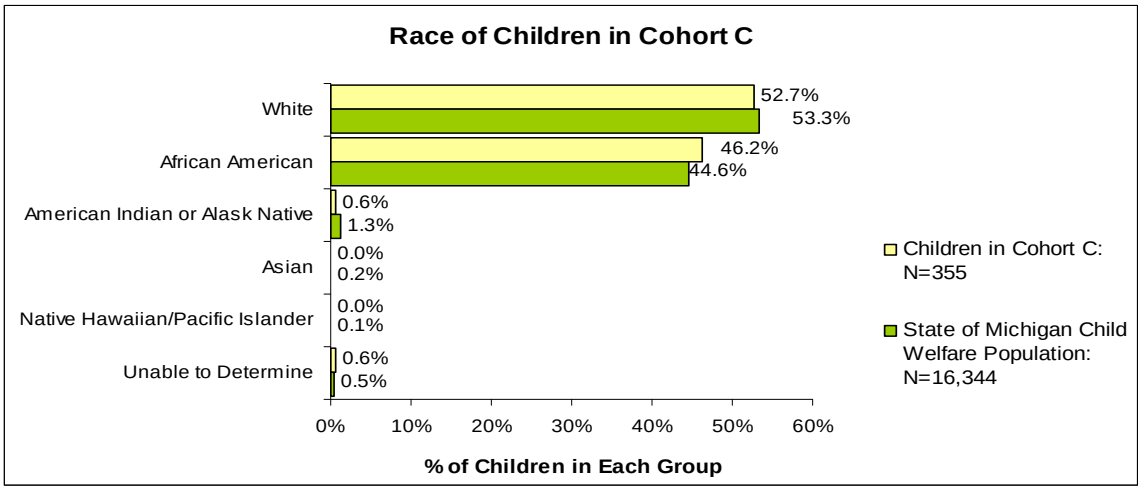
The average age of the children in this group was 12.1 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the child welfare population in Michigan as of 3/31/10.



One hundred and fifty seven of the children had a federal permanency planning goal of reunification. Eighty-eight had a goal of placement in APPLA, 84 a goal of adoption, 19 a goal of permanent placement with fit and willing relative, and seven had a goal of guardianship. The graph below illustrates the percentage breakouts and how they compare to Michigan child welfare population.



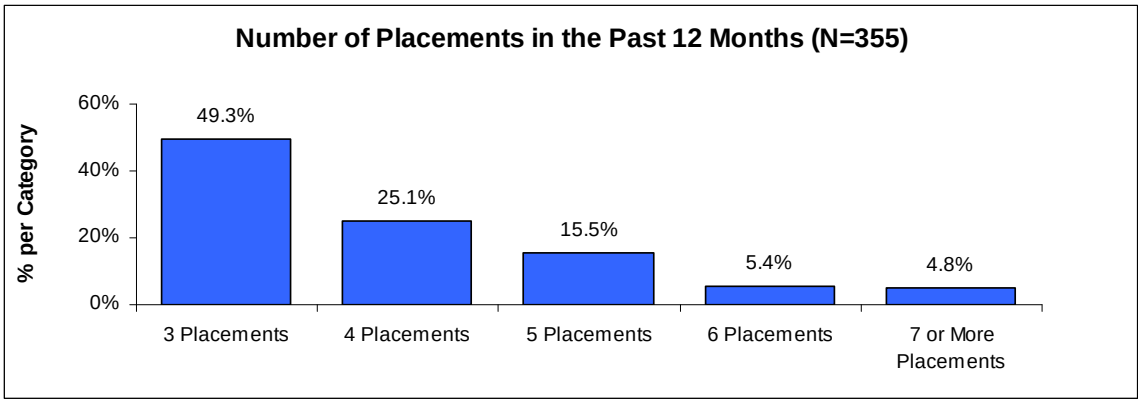
One hundred and eighty seven of the children were white, 164 were African American, two were American Indian/Alaskan Native, and two were listed as unable to determine. The graph below shows how the cases compare to Michigan child welfare population.



One hundred and eighty four of the children were male and 171 were female. Two hundred and twelve temporary court wards, 133 were Michigan Children's Institute wards, five were dual wards (court jurisdiction over a child who is a neglect ward and a delinquent ward), and four were non-wards (not delinquent), and one was a permanent court ward.

Living Arrangement	Children in Cohort C: N=355	State of Michigan Child Welfare Population: N=16,344
Parental Home	4.8%	11.1%
Lic/Unlicensed Relative	14.6%	34.5%
Adoptive Home	0.3%	2.1%
Lic Unrelated Foster Home	36.9%	34.8%
Independent Living	10.4%	6.2%
Unrelated Caregiver	2.8%	0.8%
EmergencyShelter Hm/Fac	0.8%	0.5%
Community Justice Center	0.3%	0.0%
Detention	0.8%	0.3%
Private Child Care Institution	22.3%	5.8%
DHS Training School	0.3%	0.1%
Mental Health Facility	0.8%	0.1%
Boarding School, Runaway, Services Facility, Hospital, Adult FC	0.3%	0.1%
AWOLP	3.1%	1.1%
Out of State Relative	1.4%	0.6%

One hundred and eighty children reviewed had been in four or more placements in the past 12 months. A team decision making meeting or permancy planning conference was held prior to the placement change 36 percent of the time. The average length of stay for placements was 3.7 months. The charts below show the number of placements in the past 12 months and how the number breaks out by age group.



Number of Placements in The Past 12 Months by Age Group

	0-3 Years Old	4-7 Years Old	8-11 Years Old	12-15 Years Old	16-19 Years Old
3 Placements	23	32	22	45	53
4 Placements	12	13	10	15	39
5 Placements	4	7	7	13	24
6 Placements	0	1	1	7	10
7 Placements	1	0	1	2	3
8 Placements	0	0	0	1	2
9 Placements	0	0	0	1	2
10 or More Placements	0	0	1	2	1

Quality Assurance Assessment: Cohort C

While reviewing cases for this cohort, the analysts found non-compliance with existing policies, while at that same time identified several areas for best practice recommendations and possible policy changes. The non-compliances indicate a need for improvement in oversight/monitoring of the child welfare case by both the DHS foster care worker and supervisor.

The most prominent area of policy non-compliance was the lack of documentation of preparation for replacement and reasonable efforts to preserve placement. Service specialists are not adequately documenting that they are following replacement and reasonable efforts policy. DHS policy outlines several steps that the worker must take when replacing a child in care: assessing relatives as possible placement resources; consulting with youths ages 14 and older about the replacement; documenting efforts to maintain the original placement; documenting reasonable efforts to place siblings together; documenting the reasons for the replacement and why the child was not returned to the parents, placed with siblings, or with a suitable relative; and conducting a permanency planning conference. Some or all of this information was missing from the reviewed service plans.

The L-Letter released on February 23, 2010, which mandates timely entry in SWSS of face-to-face contact with parents and children, is an important first step to proper documentation; however, it does not mandate timely documentation of all collateral contacts. Analysts consistently found that these collateral contacts are not always documented and this information is imperative to verifying information applicable to permanence and well-being. This missing information creates a barrier to the decision making process regarding the child. Furthermore, without this information in the case record, it can result in management lacking information, placing a barrier in their ability to properly monitor worker efforts or compliance in these areas.

The DHS-69, Foster Care Action Summary, which outlines all critical information for a replacement, was missing from case files or was lacking in information regarding why a youth was moved, preparation for placement, and/or why the new placement best meets the child's needs.

Policy FOM 914, "Monitoring Worker Responsibilities," includes requirements for workers to follow in order to adequately document all replacements in SWSS-FAJ. Case reviews show that this has not been consistently or adequately followed.

While reviewing the children's cases in this cohort, it was noted that a number of case files were lacking the permanency goal review (DHS-643) forms. A permanency goal review is required annually for every child in foster care. Per DHS policy FOM 722-7, "The current goals must be reviewed and determined to be appropriate. The barriers to permanency must be identified as well as the documented efforts that will be taken in accordance with an established timeline for when the child will reach permanency."

Recommendations: Cohort C

A review of all the local QIPs shows a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

- As it is not defined in policy, it is suggested that local offices develop protocol for documenting PPC activity in the USP/PWSP and a protocol for case record maintenance of the PPC activity reports.
- Review of the Foster Care Action Summary (DHS-69) to increase compliance with requirements of this form and corresponding sections of the USP.
- Review of FOM 722-3, "Placement/Replacement" and FOM 914, Monitoring Worker Responsibilities: Replacement Report.

Recommendations to Program Office:

A PPC, conducted prior to the move or within 24 hours after an emergency replacement, could effectively help address most or all of the replacement requirements. As noted above, only 36 percent of the replacements included documentation that a PPC was conducted either before the move or within 24 hours after an emergency replacement. On March 2, 2010, a memorandum was released that outlined the critical stages of a case at which a PPC is mandatory and included a thorough protocol for PPCs. The QA Unit recommends extending that memorandum to include the following:

- Outline the proper procedures for documenting the events of the PPC in the USP/PWSP.
- Include proper procedures for filing the DHS-969, Permanency Planning Conference Facilitator Report, the DHS-971, Permanency Planning Conference Activity Report, and the DHS-968, Permanency Planning Conference Attendance Report.

As mandated through the consent decree, permanency planning conferences are on an implementation schedule and are not yet required in all counties. Some regional analysts have recommended that assigned counties take proactive steps to evaluate and prepare to implement local office PPC policy to address requirements of PPC. It should be noted that some counties have already begun this and have been conducting some PPCs in their area.

- Establish policy that outlines the proper procedures for documenting the events and results of the PPC in the USP/PWSP.
- Establish policy that outlines the proper filing for the DHS-969, Permanency Planning Conference Facilitator Report, the DHS-971, Permanency Planning Conference Activity Report, and the DHS-968, Permanency Planning Conference Attendance Report.

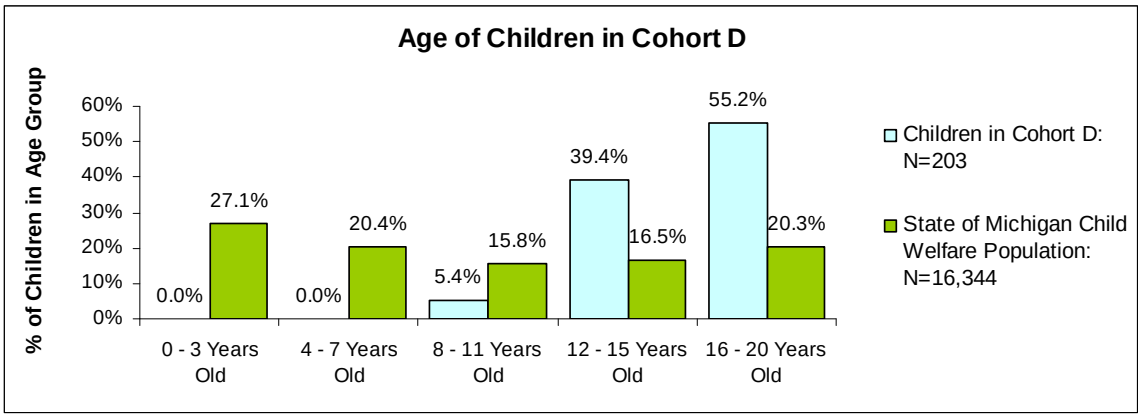
Results: Cohort D

Definition: Children who, at the time of review, have been in residential care for one year or longer.

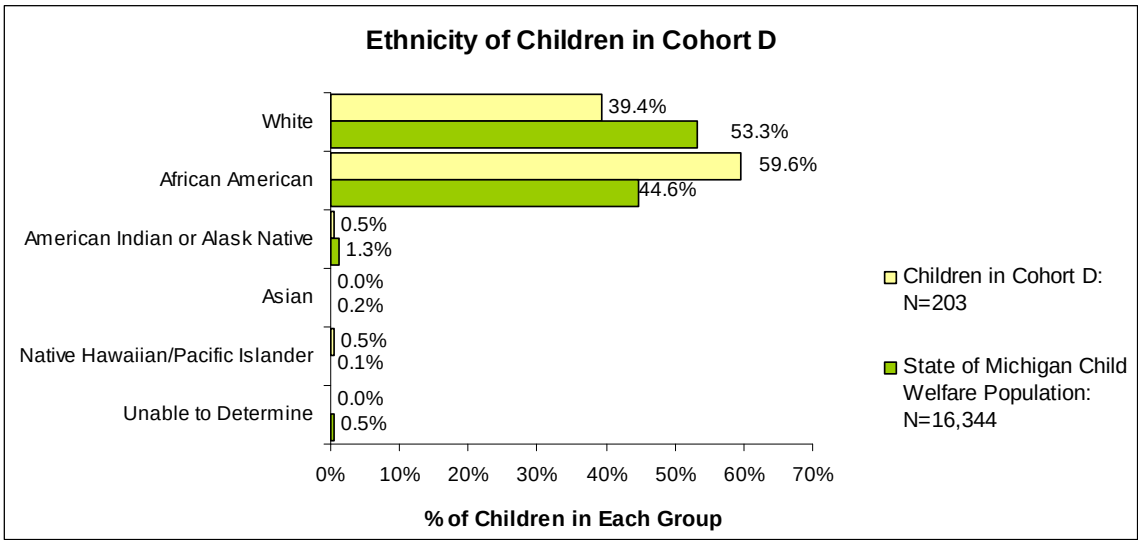
The QA Unit has reviewed 248 cases for this cohort in Report Period Three. During the pre-screening process, 45 cases were determined that they did not meet the requirements of the high-risk category at the time of review. Fourteen children were living independently, eight moved to licensed foster homes, six were no longer in residential placement, five were placed with relatives, three cases were closed, three were Juvenile Justice cases (not dual wards), two were in their own home, one was reviewed previously, one was adopted, and one was AWOL.

Two hundred and three cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. One hundred and twenty one of the cases were under the direct responsibility of DHS and 82 were under the direct responsibility of private child placing agencies.

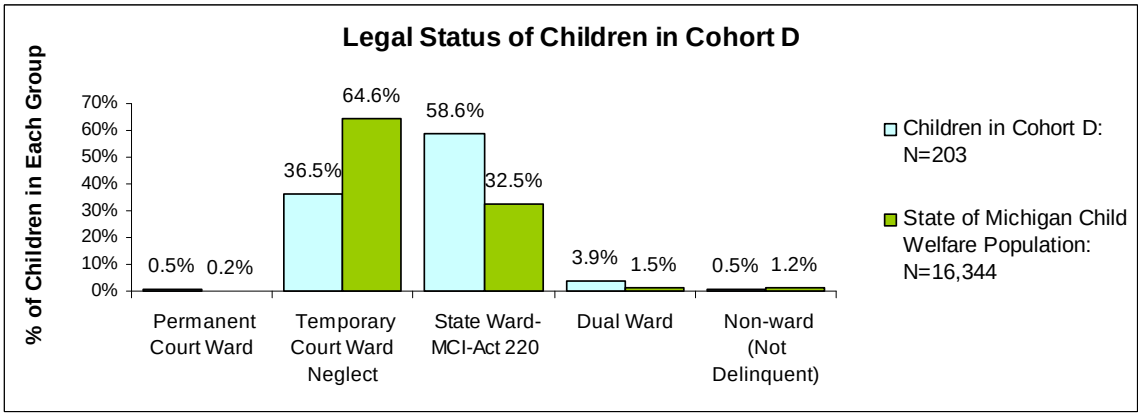
The average age of the children in this group was 15.6 years, older than the other special review cohorts and higher than 8.8 years, the average age of the children in the child welfare population. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in Michigan as of 3/31/10.



One hundred and twenty one of the children were African American, 80 were white, one was American Indian/Alaskan Native, and one was Hawaiian/Pacific Islander. The graph below shows how the cases reviewed compare to Michigan child welfare population.



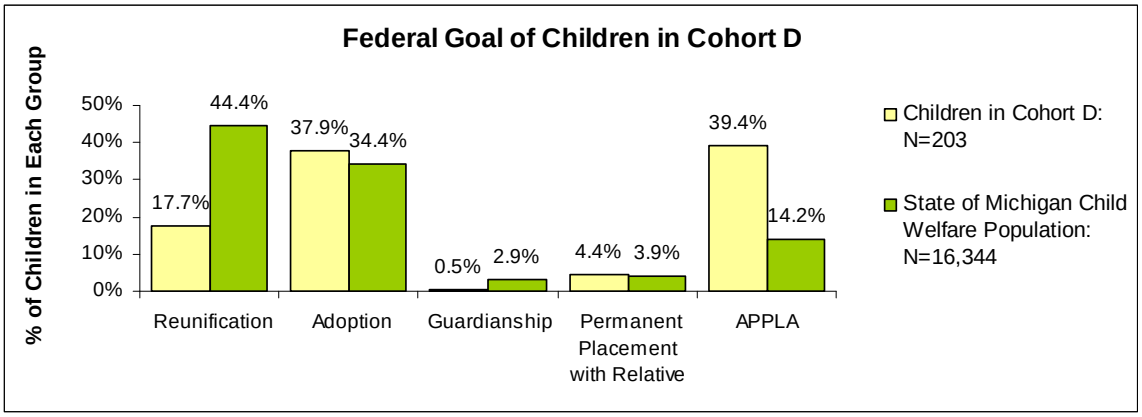
One hundred and nineteen of the children were MCI wards, 74 were TCWs, eight were dual wards, one was a permanent court ward, and one was a non-ward (not delinquent). The graph below illustrates the percentage breakouts and how they compare to Michigan child welfare population.



Two hundred children reviewed were living in a private child care institution, two were in out-of-state child care institutions, and one was in a DHS training school. One hundred and twenty five were male and 78 were female.

Eighty children had a federal permanency planning goal of placement in another planned permanent living arrangement (APPLA), 77 had a goal of adoption, 36 had a goal of reunification, nine had a goal of permanent placement with fit and willing relative, and one had a goal of guardianship.

The graph below illustrates the percentage breakouts and how they compare to the Michigan child welfare population.



The average length of time in the current residential placement for the cases reviewed was 17.6 months. The most frequent was four months, the median was 14 months and the length of time ranged from 6 days to 113 months. The average length of continuous time in residential settings for these cases was 33.6 months. One hundred and eight cases had previous residential placements.

The cases reviewed were in the following counties:

County	Cases per County
Allegan	3
Berrien	17
Calhoun	1
Cass	1
Eaton	1
Emmet	1
Genesee	19
Grand Traverse	1
Hillsdale	2
Ingham	7
Ionia	1
Jackson	1
Kalamazoo	5
Kalkaska	1
Kent	22
Lake	1
Lenawee	2

County	Cases per County
Lenawee	2
Livingston	1
Macomb	9
Menominee	1
Midland	1
Monroe	2
Muskegon	8
Oakland	13
Ogemaw	1
Ottawa	1
Roscommon	2
Saginaw	1
St Joseph	1
Van Buren	1
Washtenaw	3
Wayne	71
Wexford	1

One hundred and twenty cases (59.1%) had documentation of activities in the 90 days prior to the review to achieve permanency or place the child in a less restrictive setting. Ninety-nine cases (48.8%) contained documentation of the child's contact with significant people (birth family, siblings, pre-adoptive family) in the previous 90 days.

A total of 378 events of behavior management were documented in the 90 days prior to the review for 31 of the cases. The remainder of cases did not have documentation regarding behavior management. There were 82 events of isolation or seclusion documented in previous 90 days for 16 of the cases. The remainder of cases did not have documentation regarding isolation or seclusion.

There was documentation in 119 cases (58.6%) that the placement was clearly described as the most appropriate and least restrictive setting for the child and documentation in 120 cases (59.1%) that there are services provided to the child and/or family to transition the child to a less restrictive setting.

Quality Assurance Assessment: Cohort D

In reviewing the case files for Cohort D, analysts found that the reports are lacking documented information as to why residential placement is clearly in the child's best interest. The reasonable efforts sections of the USPs/PWSPs were lacking documentation that all avenues had been explored to transition the child to a less restrictive setting and subsequently achieve permanency. Some of our children remained in residential care well after it was determined that they had completed the program and were ready to transition to a less restrictive placement.

A number of direct foster care workers were not completing USPs for children during their time in residential placement. Workers were using the residential USP in lieu of a DHS USP; this is in noncompliance with existing policy (FOM 722-9, USP Requirements: Residential Care.)

Recommendations: Cohort D

A review of all the local QIPs shows a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

- Review of FOM 722-9, USP Requirements: Residential Care.
- Review of FOM 722-6, Developing the Service Plan; Reasonable Efforts to Finalize a Permanent Placement, including:
    - Ensure proper documentation that residential placement was the most appropriate, least restrictive setting for the youth, and provide sound rationale for the placement.
    - Ensure proper documentation of reasonable efforts to achieve permanency or place the youth in a less restrictive setting.

- Ensure proper documentation that the youth in residential care has had contact with significant people.
- Ensure proper documentation of the youth's progress in residential.

Recommendations to Program Office:

- Recommend considering that the PPC policy includes: A permanency planning conference must occur when a child has been ready for discharge from residential placement for more than 30 days and sufficient progress has not been achieved to transition the child to a less restrictive setting.

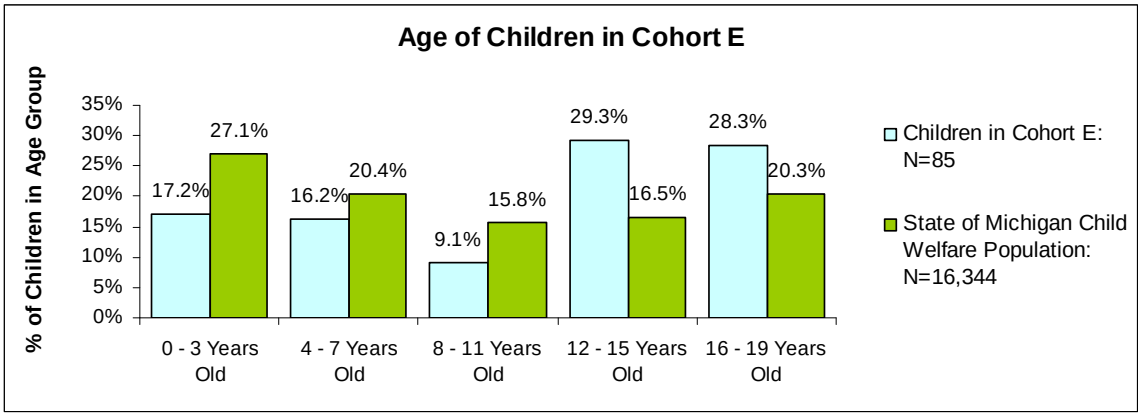
Results: Cohort E

Definition: Children who, at the time of review, are in an unrelated caregiver placement, defined as an unlicensed home in which the caregiver is not a relative of the child but has been approved as a placement resource because of prior ties to the child and/or the child's family.

The QA Unit has reviewed 153 cases for this cohort in Report Period Three. During the pre-screening process, 54 cases were determined to not meet the requirements of the high-risk category at the time of review. 21 cases were pre-screened out because the placement was licensed, eight because the case was closed, seven were adopted, five were juvenile justice cases (not dual wards), five were no longer in the placement, four were in their own home, two were living with a relative, and two cases were reviewed previously.

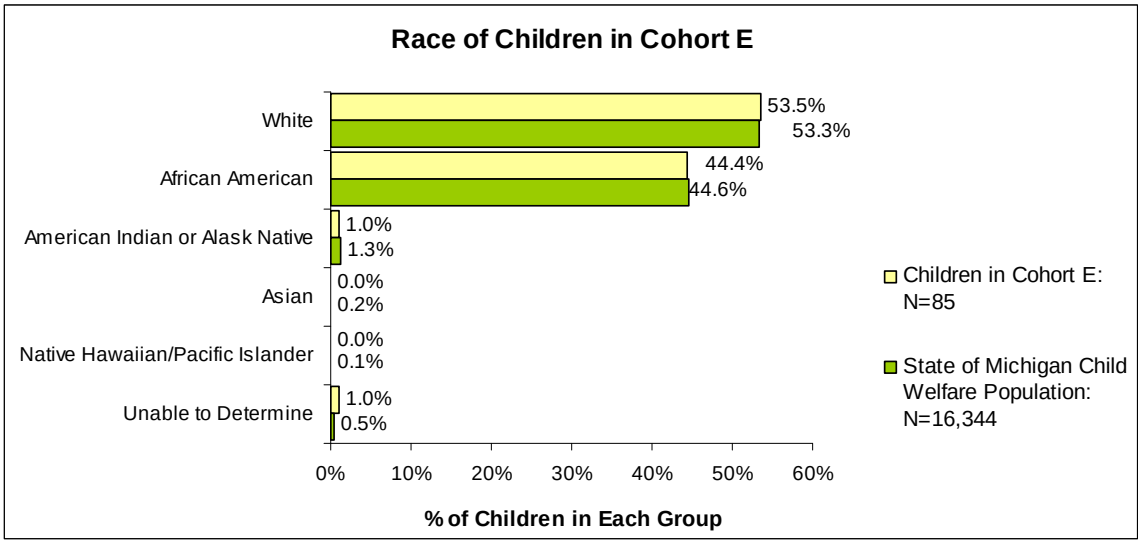
Ninety-nine cases received a comprehensive review of SWSS and the physical case file record. Eighty-eight of the cases were under the direct responsibility of DHS and 11 were under the direct responsibility of private child placing agencies.

The average age of the children in this group was 10.6 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in Michigan as of 3/31/10.

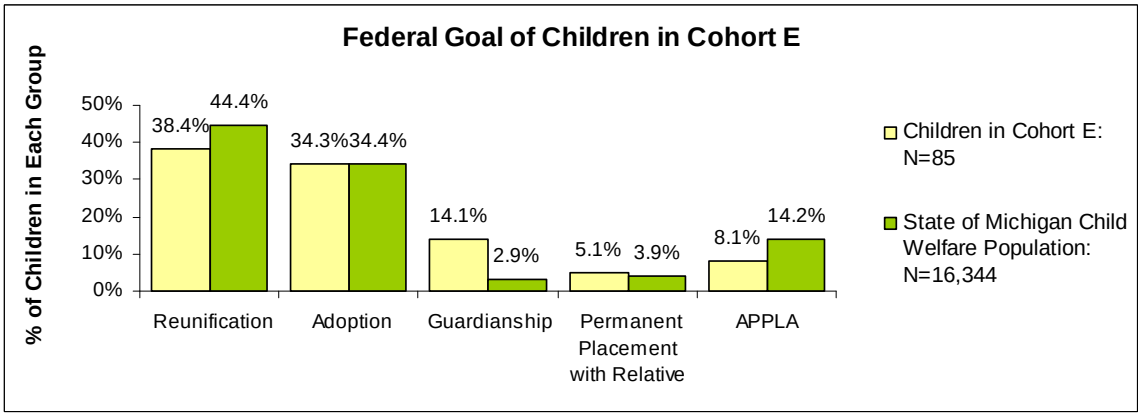


Fifty six children in this special review category were female and 49 were male. Sixty-five of the children were temporary court ward, 33 were Michigan Children's Institute wards and one was a dual ward.

53 of the children were white, 44 were African American, one was American Indian/Alaskan Native, and one was listed as unable to determine. The graph below shows how the cases reviewed compare to the Michigan child welfare population.



Thirty-eight children had a federal permanency planning goal of reunification, 34 had a goal of adoption, 14 had a goal of guardianship, eight had placement in another planned permanent living arrangement (APPLA), and five had a goal of permanent placement with fit and willing relative. The graph below illustrates the percentage breakouts and how they compare to Michigan child welfare population.



Quality Assurance Assessment: Cohort E

Child safety and permanence were the two driving factors of the QA reviews for Cohort E. At no time during Review Period Three did the analysts identify any safety concerns that demanded immediate attention in order to secure the safety of a child. Of the 99 cases, 11 of these unlicensed, unrelated caregivers had a history with CPS; all complaints were either rejected at intake or had a disposition of Category IV or V. Over 61 percent of the permanency planning goals for these children indicated that the placements are to be permanent.

In reviewing cases for this cohort, CQI analysts looked for compliance with DHS policy FOM 722-3, Unrelated Caregiver Placement. Based on this policy the following is required:

1. The court **must** approve an unrelated caregiver placement and make a finding that the "conditions of custody at the placement and with the individual with whom the child is placed are adequate to safeguard the child from the risk of harm to the child's life, physical health, or mental well-being."
2. Approval by the county director or local office designee is also required. Since this is contrary to 1973 PA 116 and CPA rule 400.12404(1), the foster care worker must submit a referral to the certification worker within one business day of the child's court-ordered placement.
3. All requirements within basic assessment process for relative placement must be completed prior to placement.

A number of court orders were either missing the required wording or the court used their own language for a recommendation. There were inconsistencies throughout the cases reviewed regarding how workers obtained approval from county directors and numerous cases were found to have no documentation at all. Home studies were not always completed thoroughly and/or filed within the case file.

Recommendations: Cohort E

A review of all the local QIPs shows a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

- Judicial training through the State Court Administrative Office to alert the judges and referees to the wording needed by DHS for these court orders. The orders should read, "Conditions of custody at the placement and with the individual with whom the child is placed are adequate to safeguard the child from the risk of harm to the child's life, physical health, or mental well-being."

- Review of FOM 722-3, Unrelated Caregiver Placement with staff and develop a plan to ensure policy requirements are met.

Conclusion

The quality assurance system is driven by DHS's commitment to delivering high quality services that provide functional, positive outcomes for the children and families we serve. The QA Unit is responsible for systematically monitoring performance expectations through the use of performance indicators. The results of the special reviews of higher risk case data will allow DHS to make informed decisions about policy, process, program effectiveness and deficits. This process of reviewing a sample of higher risk cases is a stepping stone toward the implementation of improved care across children's services with a continuous focus on safety, well-being, and permanency.

Information gathered from these reviews indicates an ongoing need for improved case management, training, and supervisory oversight. Many of the findings and recommendations relate to non-compliances with existing policies and improvements can be made with more vigilant attention to program requirements.

Follow Up

DHS continues to implement policies and develop training aimed at improving the quality of service to children and families in the child welfare system. The Quality Assurance Unit previously identified recommendations for further improvement within the department. The following steps taken by DHS address some of these recommendations.

- Field Operations and Children's Services Administration issued a joint memorandum (L-09-157-CW) on November 19, 2009 requiring all foster care, juvenile justice, and adoption case contacts be entered on SWSS-FAJ for the 2009 fiscal year by November 25, 2009. Subsequently, additional communication (L-10-019-CW) was issued on February 23, 2010 requiring DHS direct workers to enter face to face case contacts on SWSS-FAJ/CPS within 5 calendar days.

- The medical passport policy was updated on December 1, 2009 to emphasize mandated requirements. Policy on required immunizations was added with verification and documentation process outlined. On March 10, 2010 a memorandum was distributed to all foster care staff regarding required medical and dental exam entries into SWSS-FAJ. This memorandum required that the initial and yearly medical and dental examinations back to October 1, 2007 be entered on all currently open cases.

- A memorandum (L-10-034-CW) was issued on April 10, 2010 regarding the provision and tracking of health care services for children in foster care. Quarterly tracking sheets are now required from each county showing compliance with initial and yearly physical and dental exams, informed consent for all psychotropic medications, and documentation that the foster care provider is in receipt of a Medicaid card or number within 30 days of placement.

- Children's Services Administration introduced a new medical and mental health training series on January 6, 2010 to assist child welfare workers and supervisors more effectively identify and meet the medical and mental health needs of children involved with the child welfare system. The Child Welfare Training Institute, in collaboration with the DHS Medical Director, presented the ongoing training entitled Medical and Mental Health Training Series: Meeting the Needs of Children in the Child Welfare System.

- DHS announced on March 10, 2010 that it will conduct training on child welfare caseworker visitation in the summer of 2010 for foster care, juvenile justice, CPS and adoption workers and supervisors in DHS and private agency child placing agencies. Training objectives include: recognizing the relationship between visits on child safety, placement stability and permanency; reviewing policy requirements and the use of structured decision making tools for assessing child safety and affecting permanency and well-being; planning visits: and documenting the quality of the visits in services plans and SWSS.

- A memorandum (L-10-025-CW) was issued on March 2, 2010 regarding the procedures and implementation of permanency planning conferences, or PPCs. PPCs are now required at critical states of a case.

- DHS hired 26 permanency resource managers, 96 permanency planning specialists, and 72 permanency planning assistants whose roles are to assist workers in achieving appropriate permanency outcomes for children, identify the barriers to permanency, and find safe and stable permanent placements for children.