

State of Michigan Department of Human Services

Special Review of Higher Risk Cases Quarterly Report: 4/1/10 - 6/30/10



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 public systems are safe, sustain a higher quality of life while enhancing their well-being, and 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 is working to develop an internal capacity to undertake data collection, verification, and analysis in addition to completing 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 Services Worker Support System (SWSS) to pre-screen for possible data errors and ensure that the case meets the cohort definition.

The Quality Assurance Unit is responsible for systematically monitoring service quality. The QA system is driven by the department's commitment to delivering high quality services that provide functional, positive outcomes for the children

and families we serve. Analysis of the information gathered from these reviews continues to indicate an ongoing need for improved case management, training, and supervisory oversight. The results of the special reviews of higher risk cases allow the department to make informed decisions about policy, process, and program effectiveness with a focus on the safety, well-being, and permanency of those in care.

The QA Unit completed special reviews for April 1, 2010, through June 30, 2010. This report is a summary of the findings for the special case reviews conducted during this time frame.

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.

The Data Management Unit provides the QA Unit with an initial list of identified cases meeting the requirements of each special review cohort on a quarterly basis. Prior to conducting a full review, CQI analysts screen each case on this initial list to determine if the case information on SWSS continues to meet the requirements of the cohort. For all cohorts, except Cohorts A and B, if a case was previously reviewed by the QA Unit, it will be screened out for future reviews. In Cohorts A and B, if a case was reviewed in the past but another complaint of child abuse and/or neglect is called in and the youth continues to reside in the home, the CQI analyst will review the case again to determine if any actions or patterns were missed in the prior evaluation. Once the CQI analyst screens every child on the data pull list and determines eligibility, 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

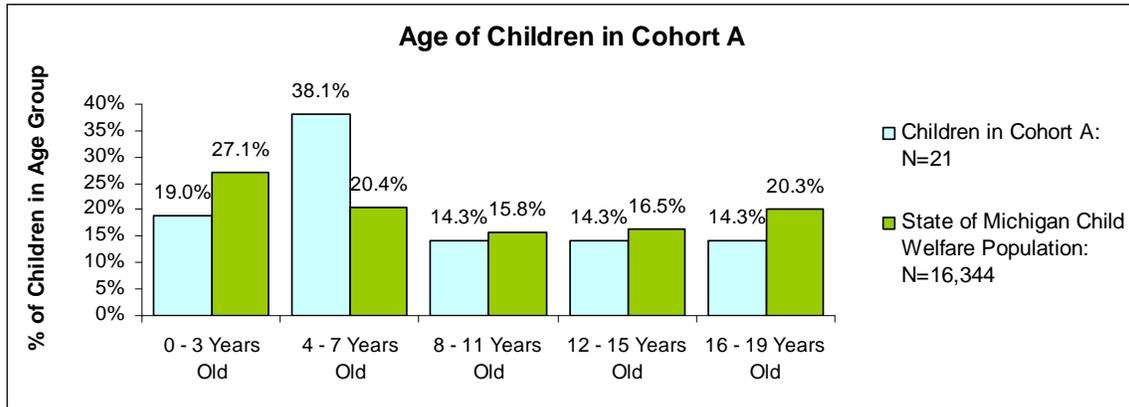
Definition: Children who have been the subject of an allegation of abuse or neglect in a residential care setting or a foster home, whether licensed or unlicensed, between June 2007 and September 2008, and who remain in the facility or home in which the maltreatment is alleged to have occurred.

One hundred and fifty-three cases were identified as meeting the requirements for this cohort on the 4/1/2010 data pull. Thirty-six new cases were added for review this quarter, giving us 189 identified cases for this cohort. The 36 new cases had been erroneously excluded from an earlier data pull because they indicated a change in the living arrangement code in SWSS but did not involve an actual change in placement.

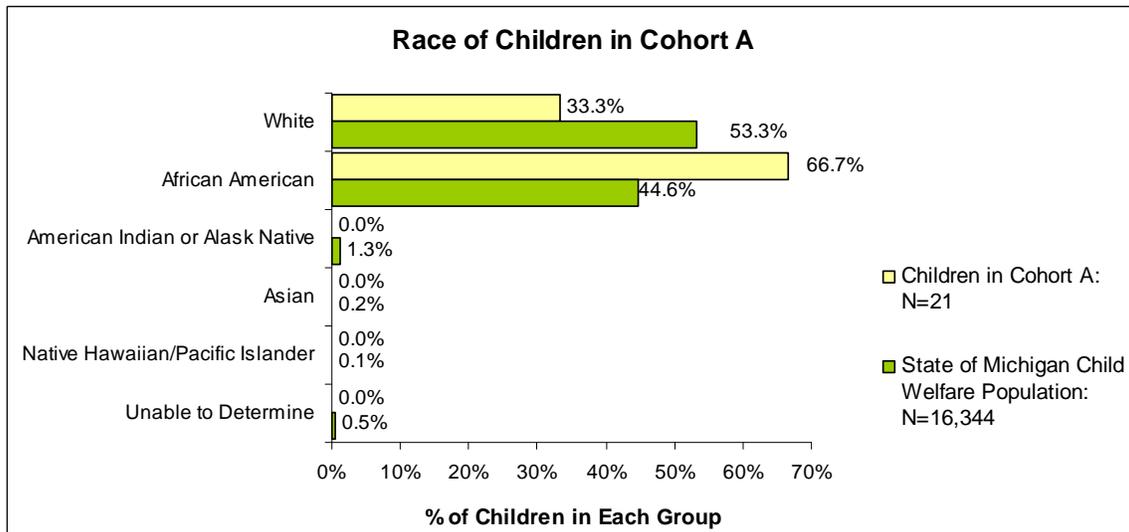
One hundred and sixty-eight of the 189 cases had either been previously reviewed by the QA Unit and there was no change since the last review or it was determined that the case did not meet the requirements of the cohort at the time of review.

Twenty-one cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. Six of the 21 cases had been previously reviewed by the QA Unit but were reviewed again this quarter because there was a new complaint since the last review. Seven of the 21 cases were under the direct responsibility of DHS and 14 were under the direct responsibility of private child placing agencies. None of the complaints included allegations of a child death.

At the time of review, the average age of the children in this group was 8.2 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.



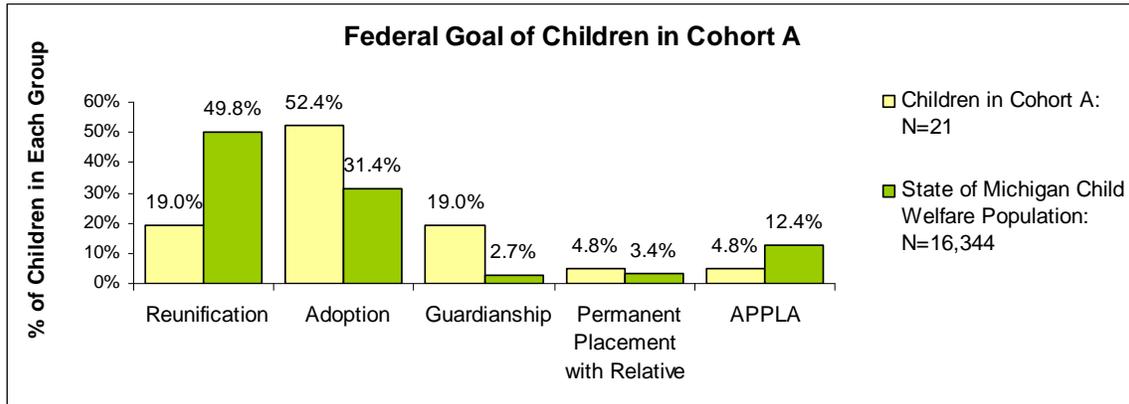
Fourteen of the children were African American and seven were white. The graph below compares the cases reviewed to the Michigan child welfare population.



Sixteen children were living with a licensed/unlicensed relative and five were living in a licensed unrelated foster home. Twelve children in this special review category were male and nine were female. At the time of review, 11 were temporary court wards and ten were Michigan Children's Institute wards.

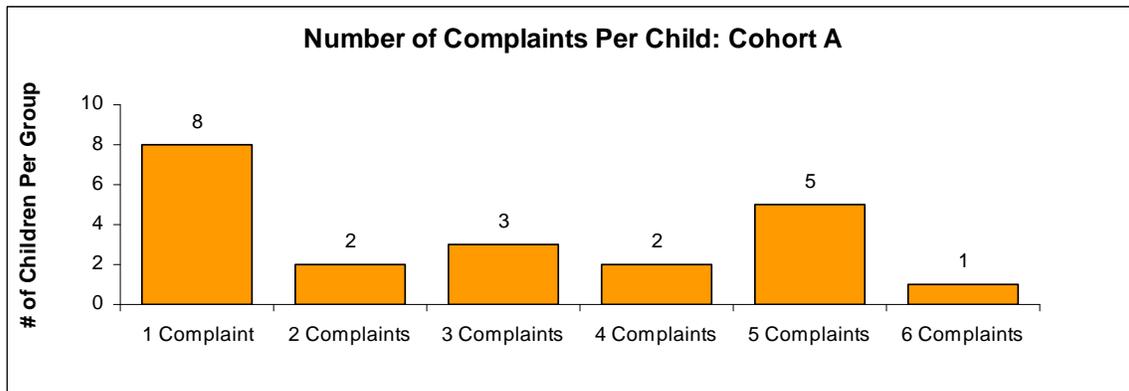
Eleven of the children had a federal permanency planning goal of adoption, four had a goal of reunification, four had a goal of guardianship, one had a goal of permanent placement with fit and willing relative, and one had a goal of

placement in another planned permanent living arrangement (APPLA). The graph below illustrates the percentage breakouts and how they compare to the Michigan child welfare population. The largest category of youths in Cohort A belongs to children who have a federal goal of adoption and are awaiting their permanent placements.

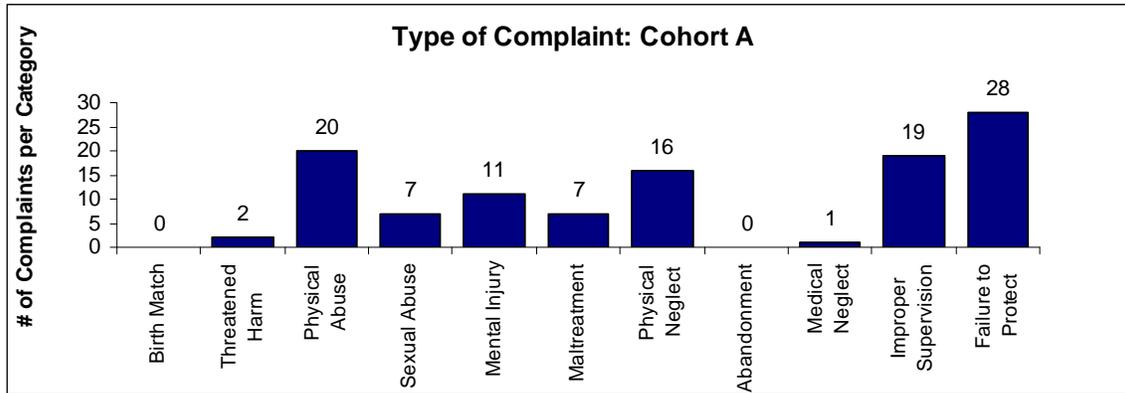


Sixteen children were from Wayne County, two were from Berrien County, two from Calhoun County, and one from St. Joseph County. The children in both Berrien and Calhoun Counties were in sibling groups placed in the same home. Six of the children in Wayne County were two separate sibling groups of three and placed in the same home.

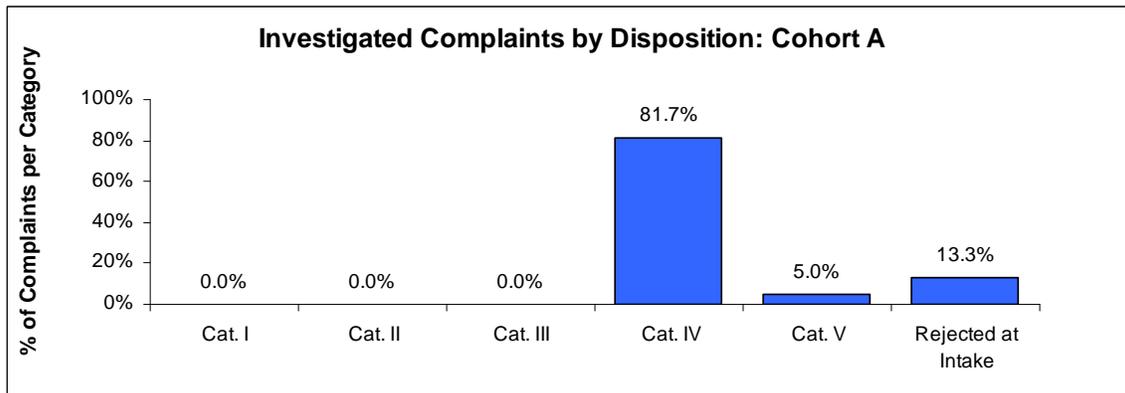
A total of 60 CPS complaints were reviewed for the 21 children in this cohort for an average of 2.9 complaints per child. The number of complaints ranged from one to six per child. The chart below shows the number of complaints per child for the reviewed complaints.



The alleged perpetrator in 44 of the complaints was a relative caregiver and in sixteen of the complaints, a foster parent. 72.7 percent of the reporters were mandated reporters. The chart on the following page shows the breakout of the complaints by the type of abuse/neglect reported.



The disposition of 49 of the complaints was no preponderance (Cat. IV), three were unsubstantiated (Cat. V), and eight were rejected at intake. Five cases were rejected because there was no reasonable cause and three were rejected because the complaint did not meet the definition of child abuse/neglect. The chart below demonstrates the disposition pattern of complaints regarding this cohort.



Quality Assurance Assessment: Cohort A

Child safety was the primary focus of the reviews in this cohort. 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 youth.

Findings indicated an inconsistency in the documentation of communication between CPS and foster care during the investigation. Some CPS case files would indicate a contact with the foster care worker, but the foster care case file would not have the corresponding contact documented. The foster care service

plan for the relevant time period documented that a CPS complaint had been made and investigated for only 17 (32.7%) of the 52 investigated complaints. Yet, during the preliminary and/or CPS investigation, CPS documented that contact was made with the assigned foster care worker in 42 (80.7%) of the complaints reviewed. In the last two quarters this has been a repeated finding in this cohort and in cohort B. Quality improvement recommendations were made to the counties to review and address this concern in June of this year and an assessment of the counties' action steps will be reviewed during the next quarter's case reviews.

In eight (53.3%) of the 15 investigated complaints that occurred in a licensed placement a copy of the CPS Safety Assessment and the Investigation Report (DHS-154) was found in the licensing certification record. In none of the cases where the alleged perpetrator was a licensed foster parent or the child resided in a licensed foster home was there record of a BCAL special investigation found in the CPS or foster care case files. These findings were also non-compliances that were noted during last quarter's case reviews. Quality Improvement Plans that identified actions to be taken locally were completed by the counties and they are currently working on these action steps.

The timeliness of report submission was an issue in almost half of the complaints reviewed. The DHS-154 Investigation Report was completed and submitted to the supervisor within 30 days of receipt of the complaint in 28 (53.8%) of the 52 investigated complaints.

Investigations were done correctly but communication was lacking in foster care and licensing. Improved communication would result in better follow up with the family to ensure concerns are addressed to help assess and prevent risk before it escalates to a CPS complaint. It is anticipated that with the development of procedures for the maltreatment in care units, along with the action steps being instituted in the local offices, we will see an increase in communication across programs, therefore eliminating this identified concern.

Results: Cohort B

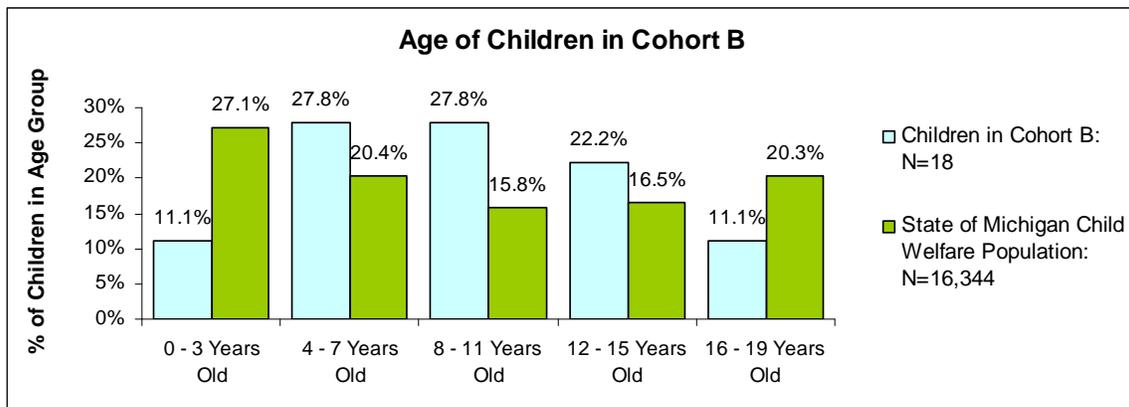
Definition: Children, not in Cohort A, who have been the subject of three or more reports alleging abuse or neglect in a foster home, the most recent of which reports was filed during or after July 2007, and who remain in the foster home in which maltreatment is alleged to have occurred.

Forty-five cases were identified as meeting this cohort on the 4/1/2010 data pull. Two new cases were added for review this quarter, giving us 47 identified cases for this cohort. These new cases had been erroneously excluded from an earlier data pull because they had a change in the living arrangement code in SWSS but did not involve an actual change in placement.

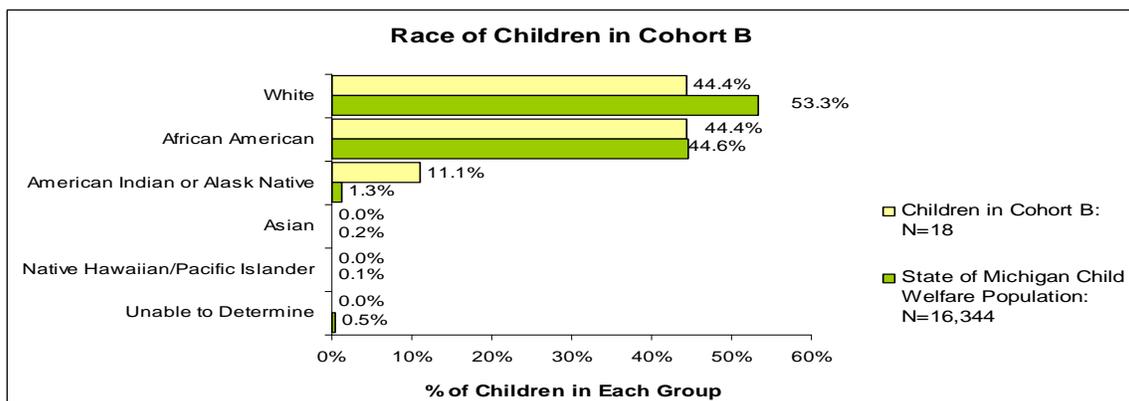
Twenty-nine of the 47 cases had either been previously reviewed by the QA Unit and there was no change since the last review or it was determined that the case did not meet the requirements of the cohort at the time of review.

Eighteen cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. Ten of the 18 cases had been previously reviewed by the QA Unit and were reviewed again this quarter because there was a new complaint since the last review. Eight new cases were identified for this cohort this quarter. Eight of the 18 cases were under the direct responsibility of DHS and 10 were under the direct responsibility of private child placing agencies. None of the complaints included allegations of a child death.

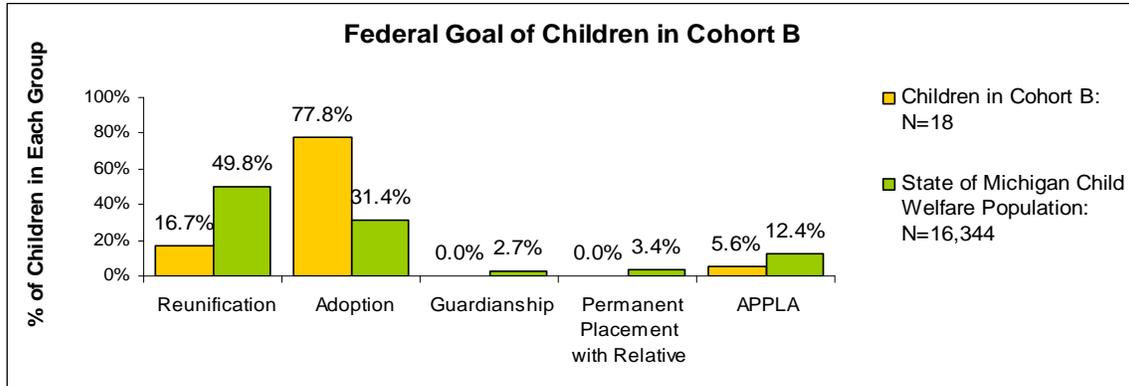
The average age of the children in this group was 9.2 years. The average age of the children in the child welfare population is 8.8 years. The graph below illustrates the age of the children and how they compare to the ages of children in the general child welfare population in Michigan as of 3/31/10.



Eight of the children were African American, eight were white and two were American Indian/Alaskan Native. The graph below shows how the cases reviewed compare to the Michigan child welfare population.



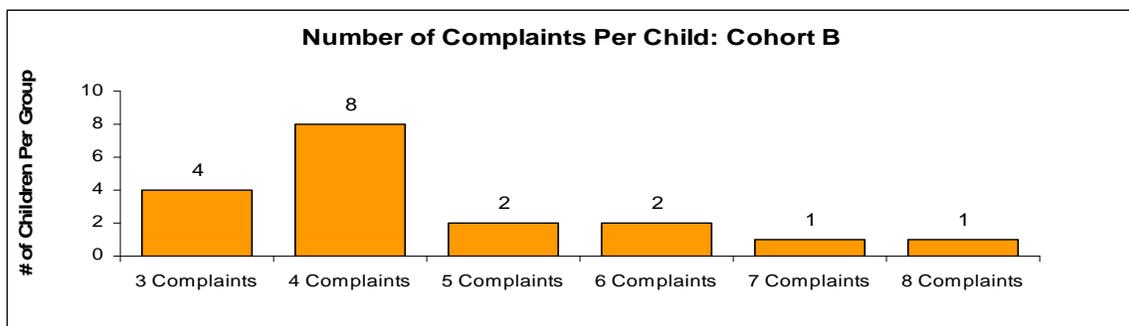
Fifteen children were living in a licensed unrelated foster home and three were living with a licensed/unlicensed relative. Eleven children in this special review category were female and seven were male. Eleven of the children were Michigan Children's Institute wards and seven were temporary court wards. Fourteen of the children had a federal permanency planning goal of adoption, three had a goal of reunification, and one had a goal of APPLA. The graph illustrates the percentage breakouts and how they compare to the Michigan child welfare population.



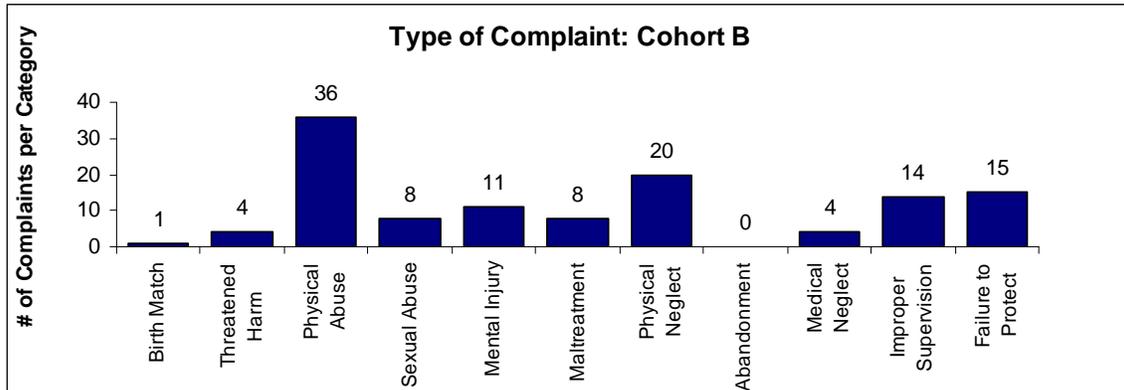
The chart below identifies the cases reviewed by county. Please note that two of the children in Genesee County, two in Mason County, and two in Wayne County were in sibling groups.

County	Cases per County	County	Cases per County
Calhoun	1	Macomb	1
Clinton	1	Mason	2
Genesee	6	Oakland	1
Jackson	1	Wayne	5

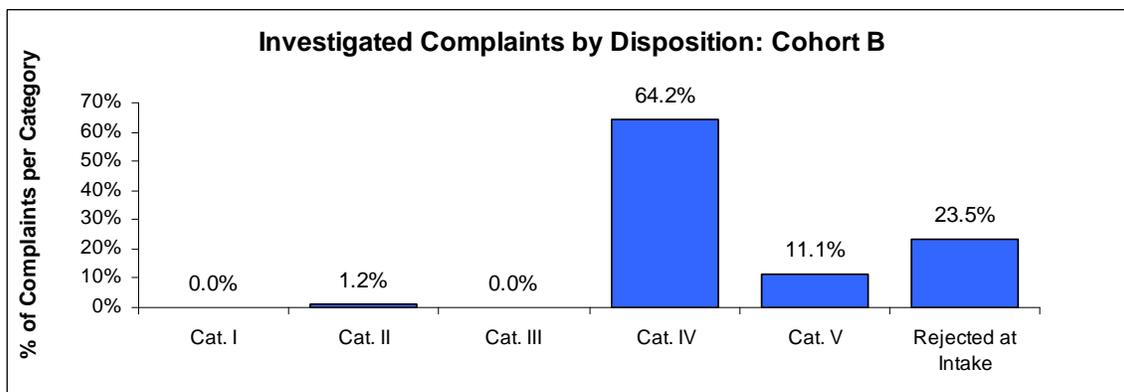
Eighty-one CPS complaints were reviewed for the 18 children in this cohort for an average of 4.5 complaints per child. The number of complaints ranged from three to eight per child. The chart below shows the number of complaints per child for the reviewed complaints.



The alleged perpetrator in 78.7 percent of the complaints was a foster parent, 16 percent were relative caregivers, 1.3 percent was another relative, and 1.3 percent was a birth parent. 2.7 percent included allegations of harm by a foster sibling. 67.9 percent of the reporters were mandated reporters. The chart below shows the breakout of the complaints by the type of abuse/neglect reported.



One case was substantiated (Cat. II) on a relative caretaker. Upon review of this case it was found that this particular caretaker had a juvenile history dating back 15 years due to sexual misconduct. CPS received numerous complaints alleging abuse and neglect to the children in the home; however, no evidence could be found to support any current risks in the home. Due to the pattern of repeated complaints, CPS determined that they would open a case based on the “threat of harm” and they provided services in the home to ensure the youth’s safety and to preserve the relative placement. Fifty-two complaints were no preponderance (Cat. IV), nine were unsubstantiated (Cat. V), and 19 were rejected at intake. Nine cases were rejected because the complaint did not meet the definition of child abuse/neglect, five were rejected because a complaint that included the same allegations was being or had been investigated and five were rejected after a preliminary investigation. The chart below demonstrates the disposition pattern of complaints regarding this cohort.



Quality Assurance Assessment: Cohort B

Findings indicated an inconsistency in the documentation of communication between CPS and foster care during the investigation. Fifty four (80.1%) of CPS case files contained documentation that contact was made with the assigned foster care worker while the foster care service plan for the relevant time period documented that a CPS complaint had been made and investigated for only 21 (32.3%) of the 65 investigated complaints. Only 18 (27.7%) of the 65 investigated complaints had a copy of the CPS Safety Assessment and the Investigation Report (DHS-154) in foster care case record.

Forty-two (64.6%) of the 65 complaints contained documentation that contact was made with the licensing/certification worker. Of the complaints where the child resided in a licensed foster home or the alleged perpetrator was a licensed foster parent, no record of a BCAL special investigation was found in either the CPS or the foster care case file. Twenty-nine (44.6%) of the 65 investigated complaints that occurred in a licensed placement contained a copy of the Investigation Report (DHS154) and the CPS Safety Assessment in the licensing case file. As stated in Cohort A, this finding has been noted in prior case reviews and quality improvement recommendations have been made to the field. An assessment of the counties' action steps will be reviewed during next quarter's case reviews.

For the investigated complaints reviewed, less than 50 percent of the investigations were completed timely. Thirty one (47.7%) of the 65 investigated complaints were completed and submitted to the supervisor within 30 days of receipt of the complaint.

As in Cohort A, the safety of the child was the primary focus of the reviews. None of the cases reviewed during this period indicated any immediate safety concerns to the youth. In one case, CPS substantiated "threatened harm," but numerous services were provided in the home and the children are deemed safe at this time. Based on the reviewed documentation, there were some identified quality assurance items for this cohort. Again, the findings indicate a concern regarding documentation of communication among the child welfare professionals during the investigation. In some cases it is apparent that communication is occurring, but the staff members are not documenting these discussions consistently across programs. It has been found that 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. This is another finding that has been noted during our last quarterly case reviews. Progress on the local offices' actions steps will be assessed during our next quarterly case review.

Maltreatment Adoption Cases

The QA Unit reviewed 74 cases in which there was an allegation of abuse or neglect in a foster home and the child has since been adopted by the same care provider. Sixty of these children were Cohort A cases and 13 were Cohort B cases. These cases are either closed in SWSS or open for adoption subsidy only. Analysts completed a review of the CPS Investigative Report (DHS-154) and information in SWSS-CPS only.

Forty-nine of these children were white and 25 were African American. Forty-five were female and 29 were male. The average age of the children in this group was nine years old. Their ages ranged from one to 18 years old. None of the complaints included allegations of a child death.

Child safety was the primary focus of the reviews in this group. 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. Out of the 49 cases that were reviewed, there was only one safety concern noted for two children who are siblings. While this case was being reviewed, the CQI analyst noted a pattern of allegations involving possible substance abuse by the adoptive parents. It was also noted that there was an overdue pending complaint that again alleged the adoptive parents were abusing substances and further alleged that the biological mother was now in the home caring for the minor children. The QA Unit immediately notified the county to assess the safety risk to these children. There continues to be a pending investigation on this case and the children are deemed safe at this time. The determination regarding the need for further services was assessed and the family will work with prevention services.

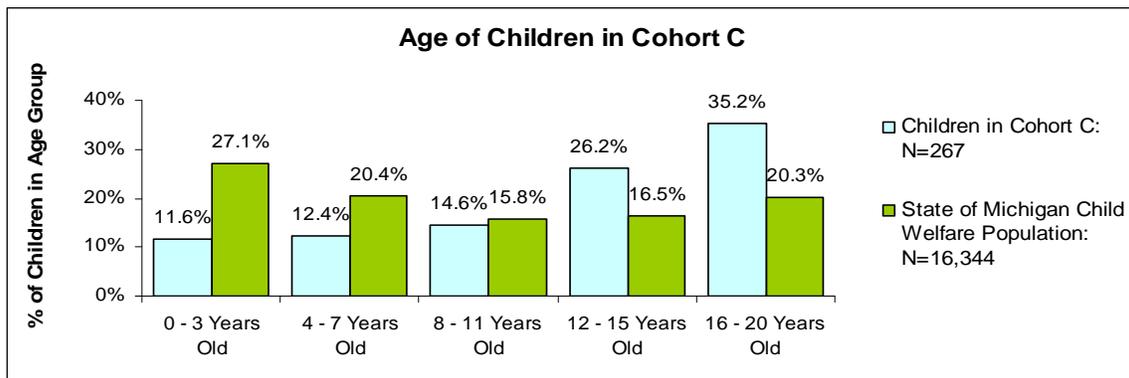
Results: Cohort C

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

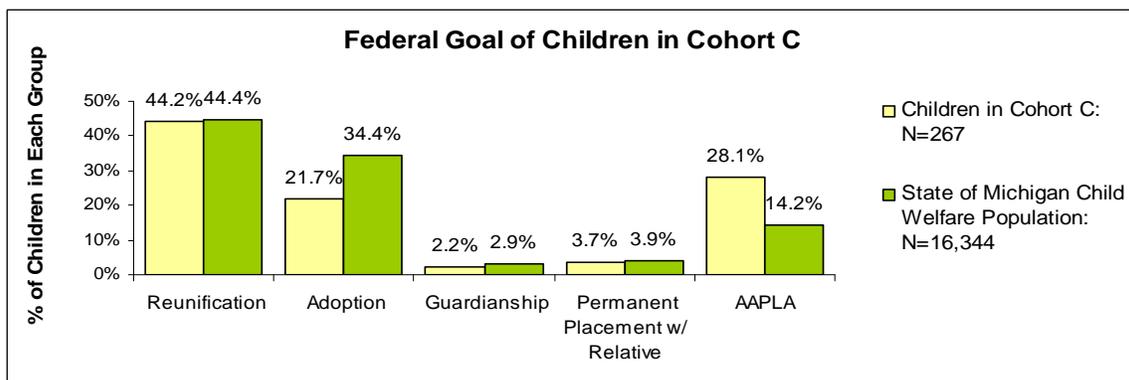
The Data Management Unit identified 2,452 cases as meeting this cohort on the 4/1/2010 data pull. Of these cases, 1,368 cases were previously reviewed by the QA Unit or it was determined that the case did not meet the requirements of the cohort at the time of review. After excluding these 1,368 cases, the QA Unit had 1,084 cases identified for review. We utilized a sample size calculator to determine a statistically significant sample size of 267 cases for this cohort.

Two hundred and sixty seven of the 2,452 cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. One hundred and sixty nine of the 267 cases were under the direct responsibility of DHS and 98 were under the direct responsibility of private child placing agencies.

The average age of the children in this group was 11.9 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.

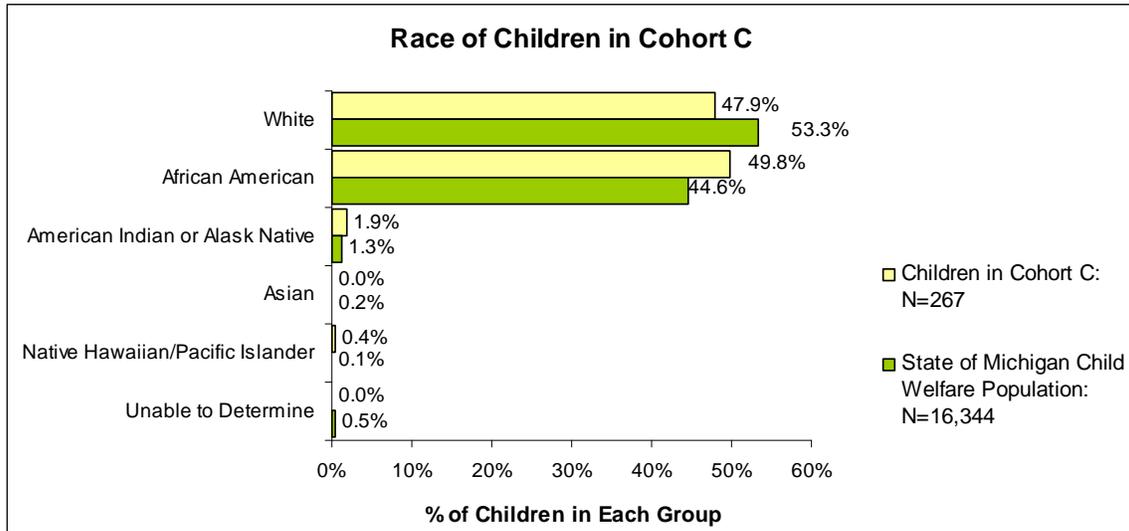


One hundred and eighteen children had a federal permanency planning goal of reunification. Seventy-five had a goal of AAPLA, 58 a goal of adoption, 10 a goal of permanent placement with fit and willing relative, and six had a goal of guardianship. The graph below illustrates how they compare to the Michigan child welfare population.



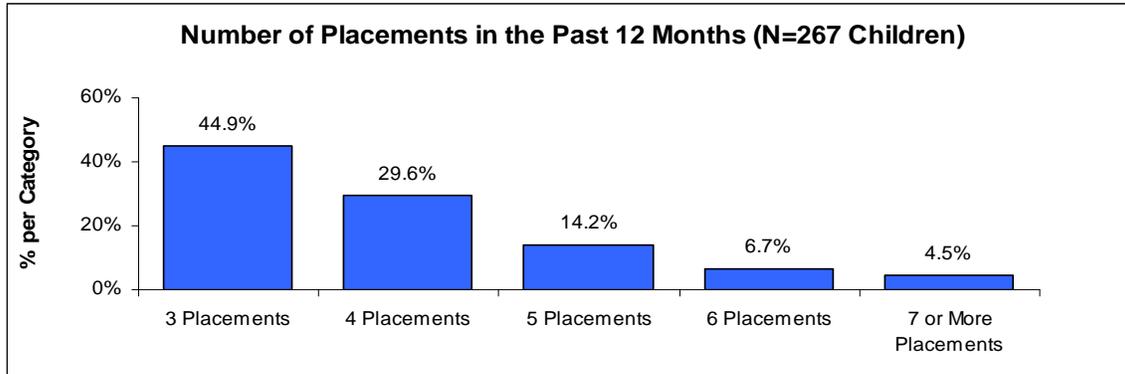
One hundred and forty-six of the children were female and 121 were male. One hundred and fifty-seven were temporary court wards, 101 were Michigan Children's Institute wards, five were non-wards (not delinquent), two were permanent court wards, and two were dual wards (court jurisdiction over a child who is a neglect ward and a delinquent ward.)

One hundred and thirty-three children were African American, 128 were white, five were American Indian/Alaskan Native, and one was listed as Native Hawaiian or Pacific Islander. The graph below shows how the cases compare to the Michigan child welfare population.



Current Living Arrangement	Children in Cohort C: N=267	State of Michigan Child Welfare Population: N=16,344
Parental Home	5.6%	11.1%
Licensed/Unlicensed Relative	20.2%	34.5%
Legal Guardian	0.4%	0.1%
Licensed Unrelated Foster Home	35.2%	34.8%
Independent Living	9.0%	6.2%
Unrelated Caregiver	0.7%	0.8%
Detention	0.7%	0.3%
Jail	0.7%	0.1%
Private Child Care Institution	21.3%	5.8%
Mental Health Facility	0.7%	0.1%
Boarding School, Runaway, Services Facility, Hospital, Adult FC	0.7%	0.1%
AWOL	3.4%	1.1%
Out of State Relative	1.1%	0.6%

Fifty-five percent of the children reviewed had been in four or more placements in the past 12 months. The average length of stay for placements was four months. The two charts below show the number of placements in the past 12 months and how the numbers break 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	20	17	21	24	38
4 Placements	5	10	13	21	30
5 Placements	6	4	3	12	13
6 Placements	1	1	0	6	10
7 Placements	0	1	0	2	2
8 Placements	0	0	1	1	1
9 Placements	0	0	0	0	2
10 or More Placements	0	0	0	0	2

The following table shows the reasons listed for placement changes for the 781 previous replacements reviewed for this cohort.

Reasons for Placement Changes:	#	%
To Achieve Child's Case Goals or Meet Specific Needs	527	67.5%
Child's Behavior - move to MORE restrictive setting	32	4.1%
Child's Behavior - move to LESS restrictive setting	6	0.8%
Caregiver Request - Child's behavior	65	8.3%
Caregiver Request - NOT based on child behavior/need	17	2.2%
AWOLP	18	2.3%
Respite	5	0.6%
Birth Parent Request	1	0.1%
Child's Request	1	0.1%
Court Order	18	2.3%
CPS Complaint Investigation	39	5.0%
Other Safety Concern - DHS Decision	28	3.6%
Foster Care Review Board Decision	0	0.0%
Licensing Requirements	5	0.6%
No Reason Documented	19	2.4%

Quality Assurance Assessment: Cohort C

Documentation of efforts by the worker to prevent replacement occurred in 347 (44.4%) of the 781 replacements. Foster care policy on placement/replacements, FOM 722-3, describes in detail the need for stability and permanency when placing and replacing children in foster homes; however, foster care policy on updated service plans, FOM 722-9, does not currently require the worker to list reasonable efforts to prevent replacement. The lack of policy that directs the need for this information can result in a lack of documentation that may lead to miscommunication. With worker turnover and changes from DHS to private child placing agency responsibilities, it can become difficult for the new worker to determine what efforts have been made to prevent multiple placements. This can result in duplicated services that are not effective or services that do not address needs. If the information is included, any new worker or supervisor would be able to see what efforts were made to prevent replacements.

Only 148 (60.3%) of the 204 Cohort C cases in care for at least one year had a permanency goal review form (DHS-643) in the case file. Foster care policy on permanency planning, FOM 722-7, requires a permanency goal review utilizing the DHS-643 to be completed annually for every foster child with a copy of the form filed in the narrative section of the case record. Almost 40 percent of the cases reviewed were missing the DHS-643. Policy does explain that a DHS-643 is to be completed annually; however, it does not state when the DHS-643 should be initially completed. It is critical that children move toward permanency and requiring the use of the DHS-643, no matter how long a child has been in care, can ensure that workers are routinely evaluating the appropriateness of the permanency goal.

In 103 (83.7%) of the DHS-643 forms found in the case files, there was documentation of reasonable efforts to finalize a permanency plan for the child. Per foster care 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." The current policy does not address the need to re-examine the barriers to permanency or efforts that will be taken to achieve permanency if the permanency goal is changed prior to the required annual review. In this case, policy could be updated to include that the DHS-643 be completed when the child's permanency goal is changed.

For 501 (64.1%) of the 781 replacements, the case file included a DHS-69, the foster care action summary, outlining critical information for a replacement. The foster care action summary is to be used whenever there is "action" on a case and, per foster care policy (FOM 722-9C), it is to be completed in all foster care cases when there is a replacement. Thirty-five percent of the replacements did not have a completed action summary.

In 527 (67.57%) of the 781 replacements, the placement change was planned in an effort to achieve the child's case goals or to meet the needs of the child. There was clear documentation of consideration given to returning the child to the parent, placing the child with siblings, or with a relative prior to the replacement in 570 (72.9%) of the 781 replacements. This indicates that most placements were appropriate due to meeting needs of the child. The numbers in this cohort do suggest that there is a need for more supportive services in the home in order to assist the caregivers with these children's special needs and possibly help prevent further placement changes.

Sixty-five of the placement changes occurred at the caregiver's request because of the child's behavior. This was the most frequent reason noted for placement changes outside of the change occurring to achieve the child's case goals or meet specific needs. A pre-determined respite process, with identified respite providers, could prevent a youth from being moved rapidly during a prolonged behavior escalation. This process could reduce the response time in an emergency, increase the chances of the current placement succeeding as opposed to the child being escalated to a more-restrictive and costly placement, and may well reduce the incidence of burnout among foster parents.

There were no safety concerns noted for this cohort.

Results: Cohort D

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

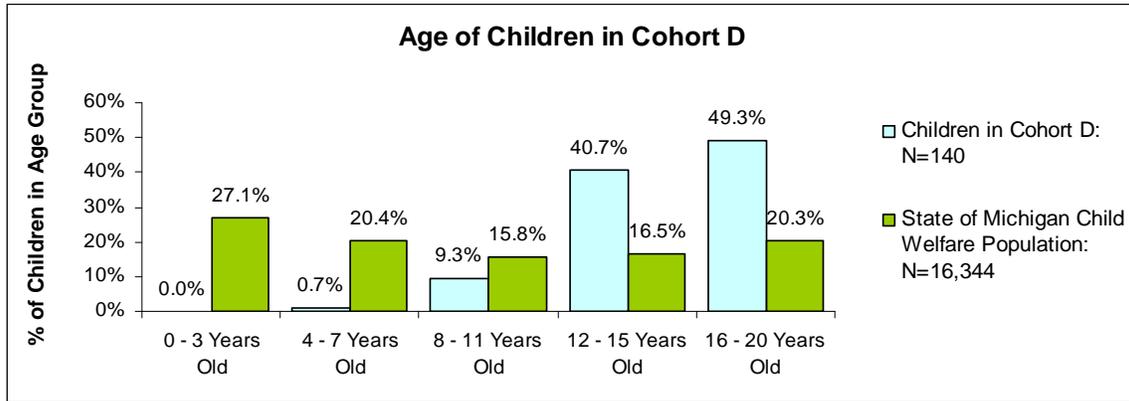
Three hundred and eighty-seven cases were identified as meeting this cohort on the 4/1/2010 data pull. Two hundred and forty-seven cases were either previously reviewed by the QA Unit or it was determined that the case did not meet the requirements of the cohort at the time of review.

One hundred and forty of the 387 cases received a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record. One hundred and thirty of the 140 cases were under the direct responsibility of DHS and 10 were under the direct responsibility of private child placing agencies.

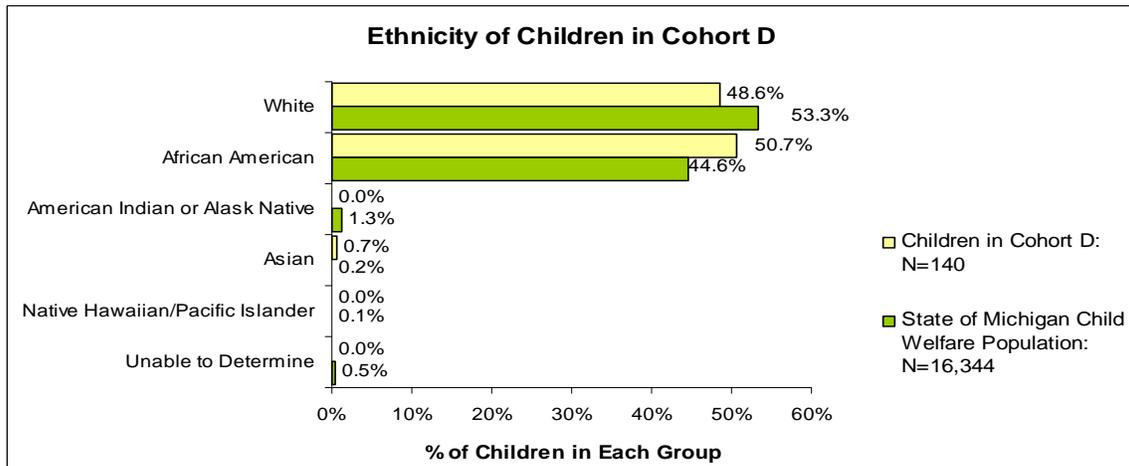
One hundred and thirty-five children were living in a private child care institution, two were in a DHS training school, one was in a mental health facility, one was in jail, and one was in an out-of-state child care institution. Eighty-six were male and 54 were female.

The average age of the children in this group was 15 years, which is older than all of the other special review cohorts and is over six years older than the

average age of the children in the child welfare population. The average age of 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.

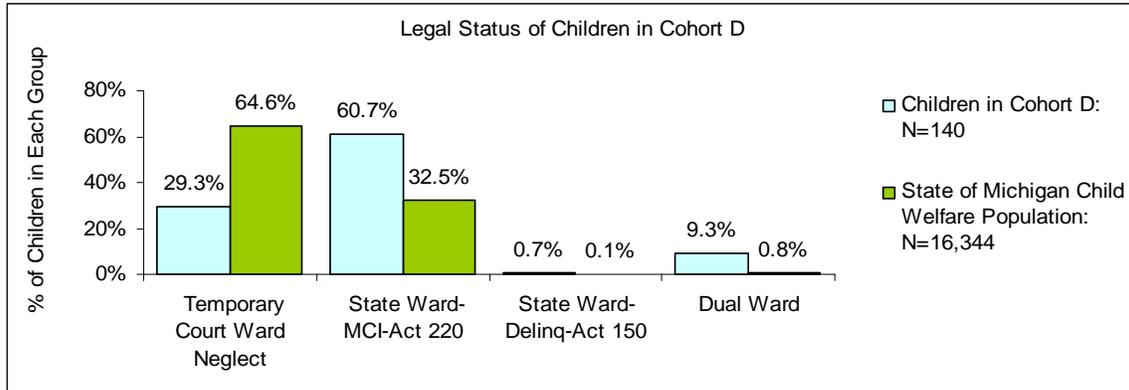


Seventy-one of the children were African American, 68 were white, and one was Asian. The graph below shows how the cases reviewed compare to Michigan's child welfare population.

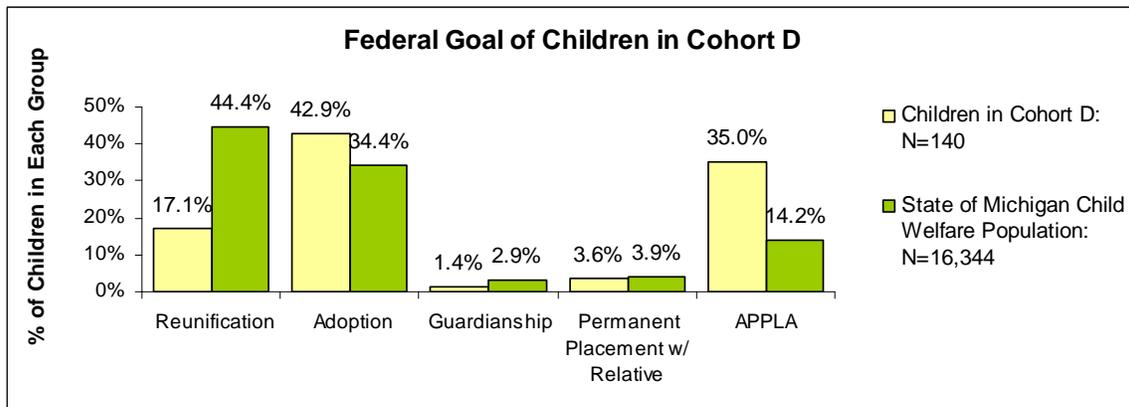


The average length of time in the current residential placement for the cases reviewed was 15.3 months. The most frequent was 15 months, the median was 14 months and the length of time ranged from 2 days to 94 months. The average length of total time in residential settings for these children was 31 months. One hundred and two of the 140 cases had previous residential placements.

Eighty-five of the children and youths were MCI wards, 41 were temporary court wards, 13 were dual wards, and one was a state ward delinquent. The graph below illustrates the percentage breakouts and how they compare to the Michigan child welfare population.



Sixty children had a federal permanency planning goal of adoption, 49 had a goal of APPLA, 24 had a goal of reunification, five had a goal of permanent placement with fit and willing relative, and two had a goal of guardianship. The graph below illustrates the percentage breakouts and how they compare to the Michigan child welfare population.



In 129 (92.1%) of the 140 cases the caseworker adequately assessed the child's mental health and behavioral health needs. In 134 (95.7%) cases services were documented in the treatment plan to address the identified needs of the youth.

The cases reviewed were in the following counties:

County	Cases per County
Alger	1
Antrim	2
Bay	1
Berrien	4
Calhoun	3
Cass	6
Charlevoix	1
Cheboygan	1
Clare	1
Crawford	1
Dickinson	2
Eaton	1
Genesee	14
Gogebic	1
Houghton	1
Ingham	4
Ionia	2
Iosco	1
Iron	1
Isabella	2
Jackson	1

County	Cases per County
Kalamazoo	6
Kent	3
Lapeer	1
Leelanau	1
Lenawee	1
Macomb	12
Marquette	1
Mason	1
Menominee	1
Midland	1
Monroe	3
Muskegon	3
Oakland	9
Osceola	1
Roscommon	1
Saginaw	3
St Joseph	3
Van Buren	1
Washtenaw	6
Wayne	31

Quality Assurance Assessment: Cohort D

One hundred and eighteen (84.3%) of the 140 residential cases reviewed contained a current residential updated service plan, but only 103 (73.6%) of the cases contained a current DHS updated service plan. Some foster care workers were not completing updated service plans for children during their time in residential placement and workers were using the residential updated service plan in lieu of a DHS updated service plan.

A total of 183 events of physical management were documented in the 90 days prior to the review for 39 of the cases. One hundred and one cases did not have documentation of physical management. There were 76 events of isolation or seclusion documented in the previous 90 days for 11 of the cases. One hundred and twenty-nine cases did not have documentation of isolation or seclusion. CQI analysts are reviewing each case and if a pattern or trend is noted on a case in

regards to the amount of seclusions/restraints, they are bringing this matter to the field's attention for closer review. No cases reviewed this period were found to have any concerns or patterns noted.

Only 85 (60.7%) of 140 of the cases reviewed in this cohort have a current approved residential placement waiver in the case file. The consent decree states that no child shall be placed in a residential treatment center without express written approval by the county administrator of Children's Services in a designated county, or by the Children's Services field manager in any other county (Section X.B.7, Limitations on Residential Care Placements).

In 119 (85%) of the 140 cases reviewed there was documentation of activities in the past 90 days to achieve permanency or place the child in a less restrictive setting. Although 85 percent of the cases documented activities to achieve permanency, it has been noted that there are numerous youths in residential care who could benefit from a residential permanency resource manager to evaluate and assist in developing a permanency plan.

The QA Unit noticed a pattern of older youth in residential placements. The average age of children in this cohort was 15 years old, which is older than any other cohort reviewed and over six years older than the average age of children in care. Some case service plans indicate that the youth is requesting that they remain in their current placement and do not want to relocate until after they have either aged out or completed their high school education. For some of the youths, it was noted that their significant support person is also a staff person in the residential facility. This finding is reinforcing the need for continued relative searches and more community-based placements for our older youths. By increasing efforts in these areas we promote opportunities for our older youth to be placed in the close proximity of their current schools and assist the youths in establishing more community supports, rather than their residential placement personnel.

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.

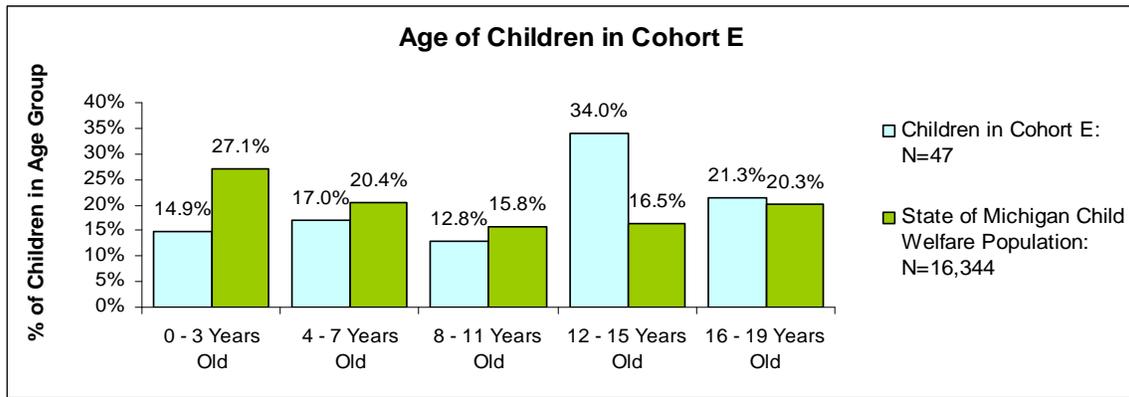
One hundred and twenty-seven cases were identified as meeting this cohort on the 4/1/2010 data pull. Eighty cases were either previously reviewed by the QA Unit or it was determined that the case did not meet the requirements of cohort at the time of review.

Forty-seven of the 127 cases received a comprehensive review of the Services Worker Support System and the physical case file record. Forty of these cases

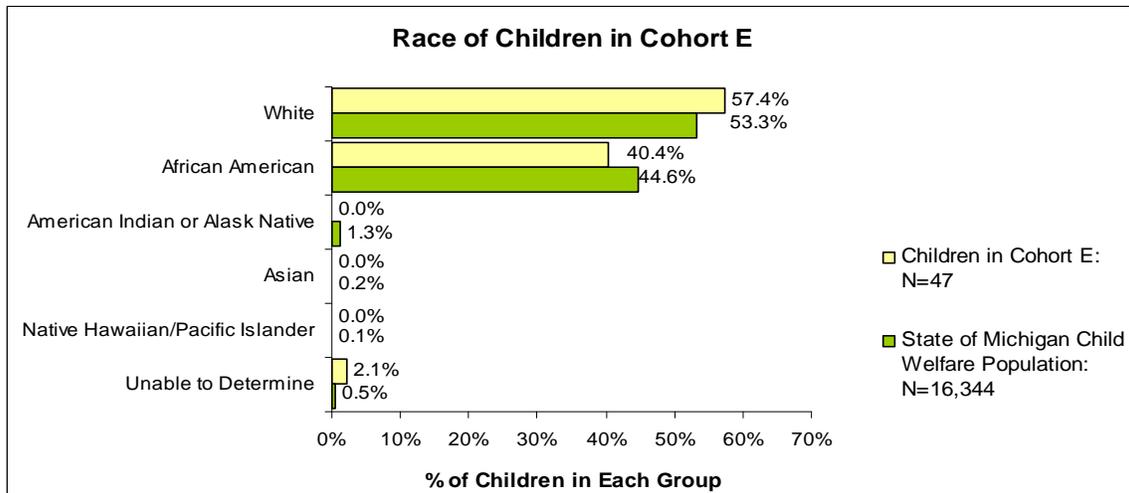
were under the direct responsibility of DHS and seven were under the direct responsibility of private child placing agencies.

Thirty children in this special review category were male and 17 were female. Thirty-three of the children were temporary court wards, 13 were Michigan Children's Institute wards, and one was a dual ward.

The average age of the children in this group was 10.4 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.

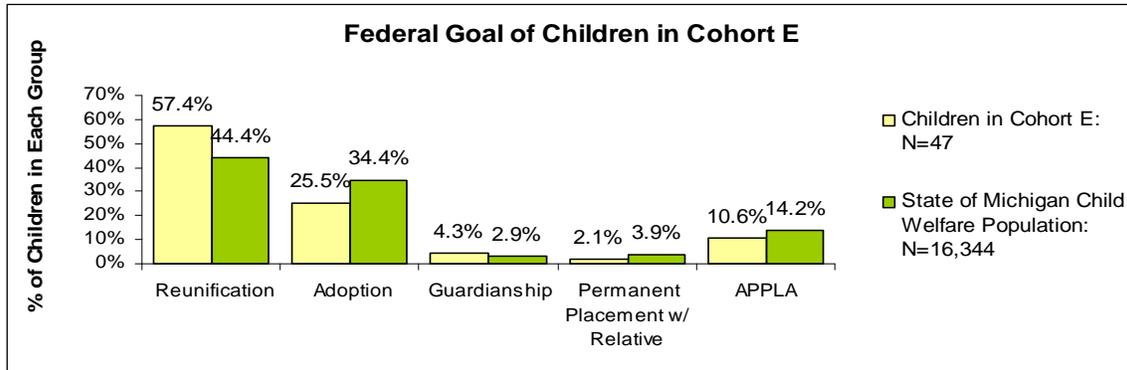


Twenty-seven of the children were white, 19 were African American, and one was listed as unable to determine. The graph below shows how the cases reviewed compare to the Michigan child welfare population.



Twenty-seven children had a federal permanency planning goal of reunification, 12 had a goal of adoption, five had a goal of placement in another planned permanent living arrangement, two had a goal of guardianship, and one had a

goal of permanent placement with fit and willing relative. The graph illustrates how they compare to the Michigan child welfare population.



The cases reviewed were in the following counties:

County	Cases per County
Branch	2
Delta	1
Eaton	1
Genesee	2
Gratiot	1
Ingham	4
Ionia	1
Kalamazoo	3
Kent	6
Livingston	1

County	Cases per County
Macomb	2
Marquette	1
Missaukee	5
Monroe	2
Montcalm	1
Oakland	2
Ogemaw	1
St Clair	3
Van Buren	2
Wayne	6

Quality Assurance Assessment: Cohort E

Child safety and permanence were primary factors of the QA reviews for this cohort. Seventeen of the 47 care providers had a history with CPS. Five of these cases are still active. There were three complaints that were determined to have a preponderance of the evidence: one was a Cat. II and two cases were Cat. III. The caregiver was listed as an “Other” and was not the perpetrator in the Cat. II case and in one of the Cat. III cases. In the second Cat. III case the caregiver is the grandmother of the victim and was found to be the perpetrator of inappropriate discipline of her own grandchild. The family was offered services and the placement was deemed safe. The remaining complaints were either rejected at intake, had a disposition of no preponderance (Cat. IV), or were unsubstantiated (Cat. V).

Home studies were not always completed and/or filed within the case file. Thirty (63.8%) of the 47 cases placed with unlicensed, unrelated caregivers included a completed home study (DHS-197). There were inconsistencies regarding how workers obtained approval from county directors and 29 (61.7%) of the 47 cases were found to have no documentation of approvals located in the case file. Of the 47 cases reviewed, the data shows that the placement was court ordered in 37 cases (78.7%). Of those, 15 (40.5%) of the 37 court orders were either missing the required wording or the court used their own language for a recommendation.

In all 47 cases there was documentation that the child was placed with people where a significant relationship existed. All children appear to be safe in these placements and none of the youths in homes with history of CPS involvement were deemed inappropriate. Children were placed with family friends in 27 percent of the 47 cases and with the family of their siblings or step-siblings in 25.5 percent of the cases. Ten percent of the placements were with teachers who knew the child.

In reviewing policy regarding the placement of children in unlicensed/unrelated homes, it was noted that there is a significant conflict between foster care and CPS policies. No youth is to be placed in an unlicensed/unrelated home without a court order authorizing the placement. CPS policy states that placement of a youth in an unlicensed/unrelated home is not allowed. Foster care policy gives specific procedures to be followed in order to make this type of placement permissible if the court orders it. It is apparent throughout reviews in this cohort that CPS workers are placing youths in unlicensed/unrelated homes and, due to a lack of procedural guidance to the CPS staff, youths are being placed without proper court documentation and/or authorization.

When conducting reviews this quarter, analysts did not identify any safety concerns that demanded immediate attention in order to secure the safety of a child.

Additional Findings

The following findings are not specific to any one cohort but reflect general themes that appear in all cases that were reviewed.

In 412 of the 480 (85.8%) applicable cases reviewed this quarter, the caseworkers made reasonable efforts on an ongoing basis to identify, locate, and evaluate maternal and paternal relatives. FOM 722-3 states that after a case is transferred from CPS to foster care, the foster care worker is to continue discussions with birth parents, age appropriate youth and other family members and document all information on the DHS-987. The DHS-987 is then to be placed in the foster care case file. There is documentation of the relative

notification form (DHS-987) in only 42 of the 480 (.08%) cases. Despite the DHS-987 being required in order to transfer a case to foster care, the data shows that this is not happening. Relative involvement in a case can provide both the parent and the child with family-based supports and possible relative placement options until reunification can be achieved. A best practice option could be that the DHS-987 is added to the permanency planning conference (PPC) facilitator's paperwork when conducting a PPC for a youth. This would ensure that the DHS-987 is initially completed and routinely updated. It has been recommended to county offices that they should review and possibly implement a local procedure encompassing this best practice.

In 221 (77.8%) of the 284 applicable cases, caseworkers completed home studies on interested relatives that addressed all of the outline criteria and included Central Registry checks and criminal history checks. Foster care policy on placement/replacement, FOM 722-3, states that when a relative meets initial considerations for placement, a basic assessment of the relative home must be completed by the foster care worker or other designated child welfare staff prior to placing the child in the home.

Two hundred and two of the 493 (40.9%) applicable cases reviewed had medical passports that had been updated in the previous 12 months. The policy regarding medical passports, FOM 722-6, states that all medical information within the medical passport must be current and updated as necessary. Workers currently enter all medical, dental, and mental health information into SWSS. SWSS does not automatically fill the medical passport with this information and duplicate entries are needed to meet this requirement which may be resulting in the non-compliance noted.

Recommendations from All Cohorts

Review of the local quality improvement plans show a consistent recommendation for the local offices to review and implement plans to ensure compliance in the following areas:

County Specific Recommendations:

- Review with CPS staff the policy requirements for the investigation report (PSM 713-10) concerning the time frame for the submission of the CPS investigation report (DHS-154).
- Review policy PSM 716-9 and develop a plan to ensure that communication is documented between foster care, CPS and the certification worker when necessary.
- Review policy and develop a plan to ensure all medical documentation, including medical passports, are maintained per policy.

- Review updated service plan policy requirements (FOM 722-9) with relevant staff and develop a plan to ensure DHS updated service plan compliance for children in residential placement.
- Review and develop a local office plan to ensure all unrelated, unlicensed placements are approved by the local office director or designee per foster care policy on placements/replacement (FOM 722-3 pg. 19).
- Review policy regarding identifying and informing relatives of foster care placement (FOM 722-3 and FOM 722-6) and develop a plan to ensure compliance with the identification of relatives by utilizing the Relative Documentation form (DHS-987).

Program Office Recommendations:

When completing the case reviews in the local office, the CQI analyst will review the case files, engage with local staff to discuss any questions or concerns that are noted in the case files, and clarify confusion or questions pertaining to case practice and policy. Based on the case reviews and through staff interviews, the following recommendations are being made to the program office:

SACWIS Unit:

- Evaluate steps that can be taken to have the SACWIS program include requirements that link to and produce updated medical information into the medical passport in order to eliminate duplicate work on the part of the services worker.

Health Unit:

- Some child welfare field staff indicated that they have come upon situations where they could use some professional guidance when dealing with some youths and their medical needs. Based on this concern, it is recommended that a process is developed to inform field staff of the Children's Services Administration's medical director, including protocols for field staff to address questions regarding service evaluations and issues or concerns with psychotropic medications.
- Develop a process that would allow field staff to request that a youth's case be assessed by a residential permanency resource manager to evaluate and assist in developing a permanency plan.
- Consider writing policy language that matches the consent decree guideline for limitations on residential care placements.

Foster Care Program Office:

- Consider a change to foster care policy on the updated service plan (FOM 722-9) to include a requirement that the worker include the reasonable efforts that were made to prevent each replacement.
- Consider revisions to policy FOM 722-7, Permanency Goal Review Process, to clarify when the Permanency Goal Review form (DHS-643) is to be initially completed and include that the DHS-643 be updated when the child's permanency goal is changed.
- Develop policy that clearly outlines case responsibility for dual wards.

Contract Compliance Unit (CCU):

- Develop guidelines for local offices regarding when to use the CCU Complaint Notification form.

Child Welfare Training Institute:

- Review the training curriculum to ensure that training reflects updated policies, particular to social work contacts with an emphasis on the need for thorough documentation and identifying relatives using the Relative Documentation form (DHS-987).

Conclusion

Our review of Cohort C and D cases indicates a need for more supportive services for our special needs youths and their foster parents. The pattern noted in these cohorts is that the youths are experiencing multiple placements or are residing in residential facilities for long periods due to their behavioral needs. Providing a more structured support system for the foster parents may result in a reduction of placement changes and, more importantly, may encourage some foster families to have youths with special needs placed into their homes. These services could also provide more placement opportunities for older youths to help prevent them from aging-out while in residential settings.

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:

- The basic assessment process for placing a child into the home of a relative was revised on 6/1/10 to include time frames for completion of the Home Study Outline (DHS-197) at the initial placement and for replacements. For initial placements, at the time the child first enters foster care, the Home Study Outline is to be completed within 30 days of the child's placement in the relative home. For replacements, the home study outline is to be completed prior to placement in the relative home.
- Foster care policy regarding timeframes for medical documentation for placement agency contracted foster care, FOM 913-1, was revised on 6/1/10 directing the contractor to follow guidelines outlined in the foster care policy, FOM 722-6 on documentation of medical, dental and mental health needs.
- Foster care policy regarding contacts with treatment and service providers, FOM 722-6, p. 5, was updated on 6/1/10 in order to clarify documentation requirements. Contacts with treatment providers must occur monthly and be documented in social work contacts and the narrative in the service plan report.
- CPS will review policy regarding medical evaluations during a CPS investigation to ensure it addresses requirements for non-communicative children. Current policy is to be reviewed by CPS program office staff, the CPS Advisory Committee, and the CPS Medical Advisory Committee. After review, policy will be amended as determined appropriate.
- DHS conducted training on child welfare caseworker visitation for foster care, juvenile justice, CPS and adoption workers and supervisors in DHS and private child placing agencies. The training focused on the importance of caseworker visitation in improving case outcomes by: recognizing the relationship between visits and 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 service plans and SWSS.