Progress of the Michigan Department of Health and Human Services

Monitoring Report for *Dwayne B. v. Snyder*

IMPLEMENTATION, SUSTAINABILITY, AND EXIT PLAN

ISEP 10

JANUARY TO JUNE 2016

ISSUED JUNE 8, 2017

PUBLIC CATALYST

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Introduction

This document serves as the eleventh report to the Honorable Nancy G. Edmunds of the United States District Court for the Eastern District of Michigan in the matter of *Dwayne B. v. Snyder*. On February 2, 2016, the State of Michigan and the Michigan Department of Health and Human Services (DHHS) and Children's Rights, counsel for the plaintiffs, jointly submitted to the court an Implementation, Sustainability and Exit Plan (ISEP) that establishes a path for the improvement of Michigan's child welfare system. Judge Edmunds had previously approved an Initial Agreement among the parties on October 24, 2008, and a subsequent Modified Settlement Agreement on July 18, 2011. DHHS is a statewide multi-service agency providing cash assistance, food assistance, health services, child protection, prevention, and placement services on behalf of the State of Michigan. Children's Rights is a national advocacy organization with experience in class action reform litigation on behalf of children in child welfare systems. Judge Edmunds entered an order directing implementation of the ISEP following its submission by the parties.

In sum, the ISEP:

- Provides the plaintiff class relief by committing to specific improvements in DHHS' care for vulnerable children, with respect to their safety, permanency, and well-being;
- Requires the implementation of a comprehensive child welfare data and tracking system, with the goal of improving DHHS' ability to account for and manage its work with vulnerable children;
- Establishes benchmarks and performance standards that the State committed to meet in order to realize sustainable reform; and
- Provides a clear path for DHHS to exit court supervision after the successful achievement and maintenance of Performance Standards for each commitment agreed to by the parties in the ISEP.

The Agreement divides commitments into three distinct sections. They are:

1. **Structures and Policies** (22 commitments) – These are structural and policy components of the DHHS child welfare system. DHHS is responsible for maintaining these commitments for the duration of the ISEP; however, structure and policy commitments will not be actively monitored unless, for good cause, the monitors request from DHHS information and data relating to any commitment in this classification. If the information and data demonstrates a substantial departure from the structure or policy commitment, the monitors may request that DHHS propose corrective action.

2. **To Be Maintained** (14 commitments) – These are commitments for which DHHS' performance, as validated by the monitors, has attained its designated performance standard or standards for at least one reporting period. These commitments will be actively monitored each reporting period.
3. **To Be Achieved** (57 commitments) – These are commitments for which DHHS' performance, as validated by the monitors, has yet to attain the required standard or standards of performance for the commitment for one reporting period. These commitments will be actively monitored each reporting period.

Commitments in the ISEP that are categorized as To Be Maintained and To Be Achieved largely focus on protecting and ensuring the safety of Michigan's children. They include:

- federal outcome measures for child safety and permanency;
- child protective service investigations;
- caseload and placement standards;
- foster home development;
- relative foster parent licensing;
- contract agency evaluations;
- caseworker visits with children and families as well as children's visits with their families;
- psychotropic medication protocols;
- well-being commitments, including health care and education; and
- accurate and timely data generation.

Notably, each commitment will become eligible for exit, subject to court approval, based on the criteria specified in the Agreement for the commitment, which unless otherwise specified, falls into one of the following three categories:

1.) Can Become Eligible for Rolling Exit: Once DHHS' performance on a commitment in this category, as validated by the monitors, has been sustained at the designated performance standard for at least two consecutive reporting periods while the commitment is in the To Be Maintained category, the commitment will become eligible for rolling exit from the Agreement.
2.) Never Eligible for Rolling Exit: A commitment in this category is ineligible for rolling exit from the Agreement and will remain in To Be Maintained, subject to full monitoring, until the Agreement terminates.
3.) Eligible to Move to Structures and Policies: Once DHHS' performance on a commitment in this category, as validated by the monitors, has been sustained at the designated performance standard for two consecutive reporting periods (which may include a

period of compliance in the To Be Achieved category), the commitment will move to Structures and Policies, where it will remain for the duration of court jurisdiction.

The parties have agreed that, with the court's approval, the Agreement will terminate when the following commitments are simultaneously met:

- Every commitment is in Structures and Policies or the To Be Maintained category; and
- DHHS has performed at the designated performance standard on every commitment in the To Be Maintained category for at least two consecutive report periods; and
- There are no requests for corrective actions or outstanding corrective actions related to any commitment in Structures and Policies.

Finally, the sections of the ISEP related to monitoring and reporting to the court remain largely unchanged from the parties' prior agreement, as do the sections regarding Enforcement, Dispute Resolution, and Attorneys' Fees.

Pursuant to the ISEP, the court appointed Kevin Ryan and Eileen Crummy of Public Catalyst to continue as the monitors, charged with reporting on DHHS' progress implementing its commitments. The monitors and their team are responsible for assessing the state's performance under the ISEP. The parties have agreed that the monitors shall take into account timeliness, appropriateness, and quality in reporting on DHHS' performance. Specifically, the ISEP provides that:

"The monitors' reports shall set forth the steps taken by DHHS, the reasonableness of these efforts, and the adequacy of support for the implementation of these steps; the quality of the work done by DHHS in carrying out those steps; and the extent to which that work is producing the intended effects and/or the likelihood that the work will produce the intended effects."

This report to the court reflects the efforts of the DHHS leadership team and the status of Michigan's reform efforts as of June 30, 2016. Defined as ISEP Period 10, this report includes progress for the first half of 2016.

The monitors wish to bring to the court's and the parties' attention that there are several commitments eligible for movement based on DHHS' performance during ISEP Period 10. DHHS achieved the required performance standard for Caseload Progression for New Employees (5.1), Permanency Indicator 2 (5.8), Permanency Indicator 3 (5.9), Permanency Indicator 4 (5.10) and Permanency Indicator 5 (5.11). These five commitments are all eligible for rolling exit after a single period of compliance; therefore, the monitors recommend to the court and the parties that these provisions exit the ISEP.

Additionally, the monitors recommend that eight commitments be moved from the "To Be Achieved" section to the "To Be Maintained" section since DHHS attained the required performance standard during ISEP Period 10. These commitments are Licensing Worker Qualifications and Training (6.4); Treatment Foster Homes (6.11); CPS Investigations, Commencement (6.20); Caseload, POS Workers (6.28); Caseload, Licensing Workers (6.29); Seclusion/Isolation (6.35); Education, Attendance (6.37) and Psychotropic Medication, Diagnosis (6.53).

Period 10 Summary of Commitments

Section	Commitment	Period 10 Achieved	Page
5.1	For CPS workers, no cases will be assigned until the completion of the first 4 weeks of pre-service training. At that point, up to 5 total cases may be assigned using the Child Welfare Training Institute (CWTI) case assignment guidelines. The first 5 cases will not include an investigation involving children under 8 years of age or children who are unable to communicate. Final caseload may be assigned after 9 weeks. For foster care and adoption workers, 3 training cases may be assigned on or after day 1 of pre-service training at the supervisor's discretion using CWTI case assignments guidelines. After completion of week 3 of pre-service training, up to 5 total cases may be assigned with supervisory approval using CWTI case assignment guidelines. Final caseload may be assigned after 9 weeks.	Yes	22
5.2	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including ensuring youth have been informed of services available through the Young Adult Voluntary Foster Care (YAVFC) program, as measured through a QAP.	No	53
5.3	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including ensuring access to independent living services through age 20, as measured through a QAP.	No	53
5.4	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including maintaining Michigan Youth Opportunities Initiative (MYOI) programming, with model fidelity, at current levels in Michigan.	Yes	55
5.5	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including maintaining established MYOI coordinators.	Yes	55
5.6	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including ensuring that all youth age 16 and older have a Family Team Meeting (FTM) occurring 90 days before planned discharge from care or within 30 days after an unexpected discharge, as measured through a QAP.	No	54
5.7	DHHS will continue to implement policies and provide services to support youth transitioning to adulthood, including ensuring that youth age 16 and older in foster care with a permanency goal of Another Planned Living Arrangement, Another Planned Living Arrangement – Emancipation, or goal of adoption without an identified family have access to the range of supportive services necessary to support their preparation for and successful transition to adulthood, as measured through a QAP.	No	54
5.8	Permanency Indicator 2 – DHHS shall achieve an observed performance of at least the national standard (43.6%) on CFSR Round 3 Permanency Indicator 2 (Of all children in foster care on the first day of a 12-month period who had been in foster care between 12 and 23 months, what percent discharged to permanency within 12 months of the first day of the 12-month period?)	Yes	24

Section	Commitment	Period 10 Achieved	Page
5.9	Permanency Indicator 3 – DHHS shall achieve an observed performance of at least the national standard (30.3%) on CFSR Round 3 Permanency Indicator 3 (Of all children in foster care on the first day of a 12-month period, who had been in foster care for 24 months or more, what percent discharged to permanency within 12 months of the first day of the 12-month period?)	Yes	24
5.10	Permanency Indicator 4 – DHHS shall achieve an observed performance of the national standard (8.3%) or less on CFSR Round 3 Permanency Indicator 4 (Of all children who enter foster care in a 12-month period who discharged within 12 months to reunification, living with a relative(s), or guardianship, what percent re-enter foster care within 12 months of their discharge?)	Yes	24
5.11	Permanency Indicator 5 – DHHS shall achieve an observed performance of the national standard (4.12) or less on CFSR Round 3 Permanency Indicator 5 (Of all children who enter foster care in a 12-month period, what is the rate of placement moves per 1000 days of foster care?)	Yes	24
5.12	DHHS shall conduct contract evaluations of all CCIs and private CPAs providing placements and services to Plaintiffs to ensure, among other things, the safety and well-being of Plaintiffs and to ensure that the CCI or private CPA is complying with the applicable terms of this Agreement.	Yes	24
5.13	DHHS shall maintain at least 34 Health Liaison Officers (HLOs)	No	50
5.14	Psychotropic Medication shall not be used as a method of discipline or be used in place of psychosocial or behavioral interventions that the child requires.	Yes	26
6.1	Safety – Recurrence of Maltreatment Within Six Months: DHHS shall ensure that all children who were victims of a substantiated or indicated maltreatment allegation during the first 6 months of the applicable reporting period, at least 94.6% were not victims of another substantiated or indicated maltreatment allegation within a 6-month period.	Compliance will be reported on this commitment in ISEP 11.	23
6.2	Safety – Maltreatment in Foster Care: DHHS shall ensure that of all children in foster care during the period, at least 99.68% were not victims of substantiated or indicated maltreatment by a foster parent or facility staff member.	Compliance will be reported on this commitment in ISEP 11.	23
6.3	Permanency Indicator 1 – DHHS shall achieve an observed performance of at least the national standard (40.5%) on CFSR Round 3 Permanency Indicator 1 (Of all children entering foster care in a 12-month period, what percent discharged to permanency within 12 months of entering foster care?)	No	24
6.4	DHHS shall continue to train licensing workers in accordance with the 3.5.09 plan approved by the Monitors.	Yes	22
6.5	DHHS shall maintain a sufficient number and array of homes capable of serving the needs of the foster care population, including a sufficient number of available placements for adolescents, sibling groups, and children with disabilities. In consultation with the monitors, DHHS will develop for each county an annual recruitment plan with foster home targets based on need and number of children in care, including targets for special populations. DHHS will implement said plan upon further input from and consultation with the Monitors.	Monitoring will begin in ISEP 11 because the first annual recruitment plans created under the ISEP became effective 10/1/2016.	35

Section	Commitment	Period 10 Achieved	Page
6.6	DHHS shall develop a placement process in each county that ensures that a child entering foster care for whom a suitable relative foster home placement is not available is placed in the foster home that is the best available match for that child, irrespective of whether that foster home is a DHHS or private CPA-operated foster home.	No	35
6.7	Children in the foster care custody of DHHS shall be placed only in a licensed foster home, a licensed facility, pursuant to an order of the court, or an unlicensed relative with a waiver.	DHHS did not provide data for all components of this provision.	37
6.8	No child in DHHS foster care custody shall be placed by DHHS or with knowledge of DHHS, in a jail, correctional, or detention facility unless such child is being placed pursuant to a delinquency charge. If it comes to the attention of DHHS that a child in DHHS foster care custody has been placed in a jail, correctional, or detention facility, and such placement is not pursuant to a delinquency charge, DHHS shall ensure that child is moved to a DHHS foster care placement as soon as practicable, and in all events within five days, unless the court orders otherwise over DHHS's objection. If a child in DHHS foster care custody is placed in a jail, correctional, or detention facility pursuant to a delinquency charge, and the disposition of such a charge is for the child to return to a foster care placement, then DHHS shall return the child to a DHHS placement as soon as practicable but in no event longer than five days from disposition, unless the court orders otherwise over DHHS objection.	DHHS did not provide data for all components of this provision.	40
6.9	DHHS shall place all children within a 75-mile radius of the home from which the child entered custody unless specified exceptions are met.	No	39
6.10.a	Siblings who enter placement at or near the same time shall be placed together unless one of the specified exceptions is met.	No	38
6.10.b	If a sibling group is separated at any time, except for the above reasons, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited. These efforts shall be documented and maintained in the case file and shall be reassessed on a quarterly basis.	No	38
6.11	At any given time, DHHS shall have at least 200 treatment foster home beds.	Yes	51
6.12	No child shall be placed in a foster home if that placement will result in: (1) more than 3 foster children in that foster home, (2) a total of 6 children, including the foster family's birth and adopted children, or (3) more than 3 children under the age of 3 residing in that foster home.	The definition of a foster home is in dispute between the parties as described in this report.	39
6.13	Children shall not remain in emergency or temporary facilities, including but not limited to shelter care, for a period in excess of 30 days, unless specified exceptions apply. No child in custody shall remain in a shelter in excess of 60 days, with no exceptions.	No	40

Section	Commitment	Period 10 Achieved	Page
6.14	Children shall not be placed in an emergency or temporary facility, including but not limited to shelter care, more than one time within a 12-month period, unless specified exceptions apply. No child experiencing a second or greater emergency or temporary-facility placement within one year may remain in an emergency or temporary facility for more than seven days.	Twelve months of data are needed to assess performance for this commitment. Monitoring will begin in ISEP 11.	40
6.15	No child shall be placed in a CCI unless specified requirements are met. The initial placement of a child into a CCI must be approved by the County Director, or in a Designated County, a county-level child welfare Administrator, and then reassessed every 90 days. No child shall be placed in a residential placement for more than six months without the express authorization, documented in the child's case file, of the director of Child Welfare Field Operations or the director's manager designee.	DHHS did not provide data for all components of this provision.	40
6.16	When placing a child with a relative who has not been previously licensed as a foster parent, DHHS shall visit the relatives home to determine if it is safe prior to placement; check law enforcement and central registry records for all adults residing in the home within 72 hours following placement; and complete a home study within 30 days.	No	36
6.17	Relative caregivers will be licensed unless exceptional circumstances exist such that it is in the child's best interest to be placed with the relative despite the relative's desire to forgo licensing.	DHHS did not provide data for this commitment.	38
6.18	DHHS must license at least 85% of newly licensed relative foster parents within 180 days of the date of placement.	No	37
6.19	Except for a direct placement by court order into an unlicensed relative home, at least 80% of all relative caregivers must either (a) have submitted a license application to DHHS and not have a child placed in their home for more than 180 days, or (b) hold a valid license.	No	37
6.20	DHHS shall commence all investigations of reports of child abuse or neglect within the timeframes required by state law.	Yes	43
6.21	DHHS shall complete all investigations of reports of child abuse or neglect within the required timeframes.	No	43
6.22.a	DHHS shall investigate all allegations of abuse or neglect relating to any child in the foster care custody of DHHS (Maltreatment in Care). DHHS shall ensure that allegations of Maltreatment in Care are not inappropriately screened out for investigation.	No	44

Section	Commitment	Period 10 Achieved	Page
6.22.b	When DHHS transfers a referral to another agency for investigation, DHHS will independently take appropriate action to ensure the safety and well-being of the child.	As this commitment was a new provision of the ISEP, requiring a period of time to develop and implement policy, DHHS and the MMT agreed to forego reporting during ISEP 10.	
6.23	95% of foster care, adoption, CPS, POS, and licensing supervisors shall be responsible for the supervision of no more than 5 caseworkers.	No	21
6.24	95% of foster care workers shall have a caseload of no more than 15 children.	No	20
6.25	95% of adoption caseworkers shall have a caseload of no more than 15 children.	No	20
6.26	95% of CPS caseworkers assigned to investigate allegations of abuse or neglect, including maltreatment in care, shall have a caseload of no more than 12 open investigations.	No	21
6.27	95% of CPS caseworkers assigned to provide ongoing services shall have a caseload of no more than 17 families.	No	21
6.28	95% of POS workers shall have a caseload of no more than 90 children.	Yes	20
6.29	95% of licensing workers shall have a workload of no more than 30 licensed foster homes or homes pending licensure.	Yes	21
6.30	Supervisors shall meet at least monthly with each assigned worker to review the status and progress of each case on the worker's caseload. Supervisors shall review and approve each service plan. The plan can be approved only after the supervisor has a face-to-face meeting with the worker, which can be the monthly meeting.	DHHS did not provide data for all components of this provision.	41
6.31	DHHS shall complete an Initial Service Plan (ISP), consisting of a written assessment of the child(ren)'s and family's strengths and needs and designed to inform decision-making about services and permanency planning, within 30 days after a child's entry into foster care.	No	41
6.32	For every child in foster care, DHHS shall complete an Updated Service Plan (USP) at least quarterly.	No	41
6.33	Assessments and service plans shall be of sufficient breadth and quality to usefully inform case planning and shall accord with the requirements of 42 U.S.C. 675(1). To be measured through a QSR.	No	27
6.34	DHHS shall ensure that the services identified in the service plan are made available in a timely and appropriate manner to the child and family, and shall monitor the provision of services to determine whether they are of appropriate quality and are having the intended effect. To be measured through a QSR.	The parties did not agree on a performance standard for this commitment.	27

Section	Commitment	Period 10 Achieved	Page
6.35	All uses of seclusion or isolation in CCIs shall be reported to the Division of Child Welfare Licensing for appropriate action.	Yes	26
6.36	DHHS shall take reasonable steps to ensure that school-aged foster children receive an education appropriate to their needs. To be measured through a QSR.	The parties did not agree on a performance standard for this commitment.	29
6.37	DHHS shall take reasonable steps to ensure that school-aged foster children are registered for and attending school within 5 days of initial placement or any placement change, including while placed in child care institutions (CCIs) or emergency placements. To be measured through a QAP.	Yes	52
6.38	DHHS shall make reasonable efforts to ensure the continuity of a child's educational experience by keeping the child in a familiar or current school and neighborhood, when this in the child's best interests and feasible, and by limiting the number of school changes the child experiences. To be measured through a QSR.	The parties did not agree on a performance standard for this commitment.	29
6.39	Each child in foster care shall be visited by a caseworker at least 2x per month during the child's first 2 months of placement in an initial or new placement, and at least 1 time per month thereafter. At least 1 visit each month shall take place at the child's placement location and shall include a private meeting between the child and the caseworker.	Unable to verify DHHS' performance on this commitment.	42
6.40	Caseworkers shall visit parents of children with a goal of reunification at least 2x during the first month of placement, with at least 1 visit in the parent's home. For subsequent months, visits must occur at least once per month, with at least 1 contact in each 3 month period occurring in the parent's place of residence.	Unable to verify DHHS' performance on this commitment.	43
6.41	DHHS shall ensure that children in foster care with a goal of reunification shall have at least twice-monthly visitation with their parents, unless specified exceptions exist.	Unable to verify DHHS' performance on this commitment.	43
6.42	DHHS shall ensure that children in foster care who have siblings in custody with whom they are not placed shall have at least monthly visits with their siblings who are placed elsewhere in DHHS foster care custody, unless specified exceptions exist.	DHHS did not provide data on this commitment.	42
6.43.a	At least 85% of children shall have an initial medical and mental health examination within 30 days of the child's entry into foster care.	No	49
6.43.b	At least 95% of children shall have an initial medical and mental health examination within 45 days of the child's entry into foster care.	No	49
6.44	At least 90% of children shall have an initial dental examination within 90 days of the child's entry into care unless the child has had an exam within 6 months prior to placement or the child is less than 4 years of age.	No	49

Section	Commitment	Period 10 Achieved	Page
6.45	For children in DHHS custody for 3 months or less at the time of measurement: DHHS shall ensure that 95% of children in this category receive any necessary immunizations according to the guidelines set forth by the American Academy of Pediatrics within 3 months of entry into care. To be measured through a QAP.	No	48
6.46	For children in DHHS custody longer than 3 months at the time of measurement: DHHS shall ensure that 95% of children in this category receive all required immunizations according to the guidelines set forth by the American Academy of Pediatrics. To be measured through a QAP.	No	48
6.47	Following an initial medical, dental, or mental health examination, at least 95% of children shall receive periodic and ongoing medical, dental, and mental health care examinations and screenings, according to the guidelines set forth by the American Academy of Pediatrics.	No	49
6.48	DHHS shall maintain an up-to-date medical file for each child in care containing the information required by DHHS Policy FOM 722-05 or any successor policy approved by the Monitors. To be measured through a QAP.	No	48
6.49	At the time a child is placed or re-placed, the foster care provider shall receive the child's Medical Passport, which must contain the information required by MCL 722.954c(2) and DHHS Policy FOM 801. To be measured through a QAP.	No	48
6.50	DHHS shall provide case service plans containing the information required by DHHS policy FOM 801 (Medical, Dental, and Mental Health Consent). To be measured through a QAP.	No	48
6.51	DHHS shall ensure that at least 95% of children have access to medical coverage within 30 days of entry into foster care by providing the placement provider with a Medicaid card or an alternative verification of the child's Medicaid status and Medicaid number as soon as it is available.	No	50
6.52	DHHS shall ensure that at least 95% of children have access to medical coverage within 24 hours or the next business day following subsequent placement by providing the placement provider a Medicaid card or an alternative verification of the child's Medicaid status and Medicaid number as soon as it is available.	No	50
6.53	Prior to initiating each prescription for psychotropic medication, the child must have a mental health assessment with a current DSM-based psychiatric diagnosis of the mental health disorder.	Yes	51
6.54	DHHS shall ensure that informed consent is obtained and documented in writing in connection with each psychotropic medication prescribed to a child in DHHS custody.	Per the ISEP, monitoring of this commitment will begin in ISEP 11.	
6.55	DHHS shall ensure that the administration of psychotropic medication to children in DHHS custody is documented in accordance with the "Documentation" section in DHHS Policy FOM 802-1 (dated 5-1-2015) or any successor policy approved by the monitors.	Per the ISEP, monitoring of this commitment will begin in ISEP 11.	

Section	Commitment	Period 10 Achieved	Page
6.56	DHHS shall ensure that a qualified physician completes and documents an oversight review of a child whenever one or more of the criteria listed in the "Psychotropic Medication Oversight" section of DHHS Policy FOM 802-1 or any successor policy approved by the Monitors are met. To be measured through a QAP.	DHHS reported they will begin to implement a QAP on this commitment in ISEP 11.	
6.57	DHHS shall continue to generate from automated systems and other data collection methods accurate and timely data reports and information until the full implementation of MiSACWIS. DHHS shall generate from MiSACWIS accurate and timely reports and information regarding the requirements and outcome measures set forth in this Agreement.	No	29

Methodology

The monitoring team conducted independent verification activities that included: meetings with DHHS leadership, private agency leadership and plaintiffs' counsel; visits to private agencies; and extensive reviews of individual case records and other documentation. The monitoring team conducted joint verification activities with DHHS that included participation in two Quality Assurance Process (QAP) reviews and two Quality Service Reviews (QSRs). The QSRs covered nine counties and included: 1) interviews with DHHS stakeholders such as the judiciary staff, guardian ad litem, foster parents, service providers, public and private agency caseworkers and supervisors; and 2) case specific interviews with individuals involved in case decision making including children, parents, caregivers, public and private caseworkers, teachers, and therapists.

The monitoring team interviewed staff and supervisors and talked to public and private managers about the pace, progress, and challenges of the reform work. The monitoring team also reviewed and analyzed a wide range of aggregate and detail data produced by DHHS, and reviewed policies, memos, and other internal information relevant to DHHS' work during the period. The monitoring team reviewed over 800 distinct reports from the Department including QAP material, individual case records, Division of Child Welfare Licensing (DCWL) reports and CPS investigations.

Demographics

DHHS produced demographic data from January 1, 2016 through June 30, 2016. DHHS data indicate that there were 12,216 children in custody as of June 30, 2016. Of the children and youth in care on June 30, 2016, 443 youth were enrolled in the Young Adult Voluntary Foster Care (YAVFC) program. During the reporting period, 3,442 children and youth were placed in foster care and 3,348 children and youth exited care.[1] DHHS served 15,378 children during the reporting period.[2] Though young children aged zero to six years made up the largest portion

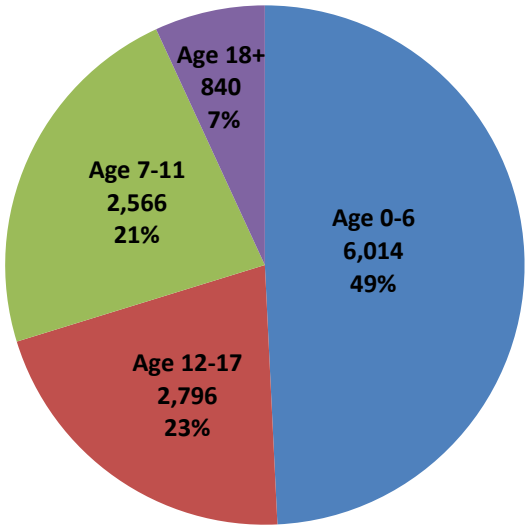
[1] The monitors made several adjustments in reporting these data. The monitoring team omitted 53 children with duplicate entries from the original DHHS data submission (1.5 percent of all listed entries) and 45 children listed by DHHS as entering twice but who exited and re-entered on the same day or the following day ("continuous stays"). Eight children appeared in the original DHHS data as entering twice in two distinct foster care spells. The monitoring team omitted 49 children listed twice by DHHS with the same data in the exit file (1.5 percent), 23 exits that were part of continuous stays, and 24 exits that were part of overlapping spells in which the DHHS data show a child exiting care twice on the same day, albeit with two distinct entry dates. These data include two children who appear to have exited foster care twice as part of two distinct foster care spells.

[2] The monitors omitted 352 children (2.3 percent) listed twice in the file submitted by DHHS describing children served during the period. The reported number of children served also omits 207 continuous stays, 26 overlapping spells, and 60 children listed twice with two different entry dates, but with no discharge date for either entry.

(6,014 or 49 percent), Michigan continued to serve a large population of older youth in custody. Twenty-three percent (2,796) of youth in custody were 12 to 17 years of age, and seven percent (840) were 18 years and over, as detailed in Figure 1.

Figure 1. Age of Children in Custody on June 30, 2016

n=12,216



The population was about equally split with regard to gender, with 50.5 percent of children in care male and 49.5 percent of children in care female. With regard to race, the population of children was 55 percent White, 29 percent African-American, 14 percent mixed race, one percent Native American, under one percent Asian, and under one percent Native Hawaiian or Pacific Islander. Seven percent of children were identified with Hispanic ethnicity of any race. The race of less than one percent of the children was undetermined.

Table 1. Race of Children in Custody on June 30, 2016

Race	Count	Percent
White	6,779	55%
Black/African American	3,592	29%
Mixed Race	1,733	14%
Native American, Asian, Pacific Islander	89	1%
Unable to Determine	23	0%
Total	**12,216**	**100.0%**
Hispanic ethnicity (of any race)	896	7%

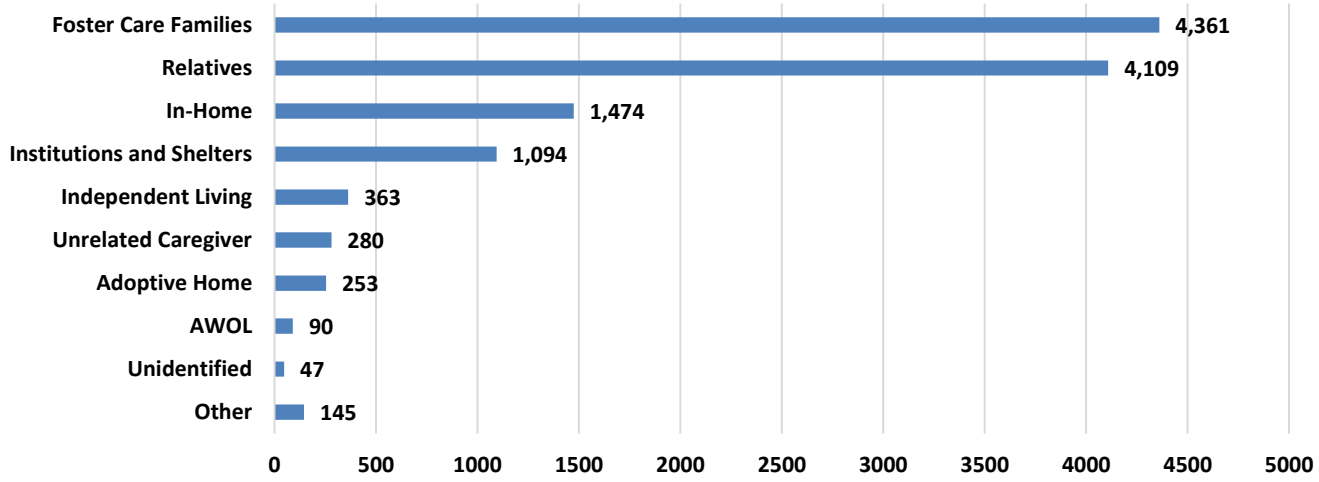
Note: Percentages may not add to one hundred due to rounding.

As Figure 2 indicates, 86 percent of children in DHHS' custody lived in family settings, including relatives (34 percent), foster families (36 percent), in their own home with their parents (12

percent),[3] in homes that intend to adopt (2 percent), and in homes of unrelated caregivers (2 percent). Of children in custody, 1,094 (9 percent) lived in institutional settings, including residential treatment and other congregate care facilities. Another 363 youth (3 percent) resided in independent living placements, which serve youth on the cusp of aging-out of care. The remaining two percent resided in other settings, were AWOL, or were in unidentified placements.

Figure 2. Placement Types of Children in Custody on June 30, 2016

n=12,216

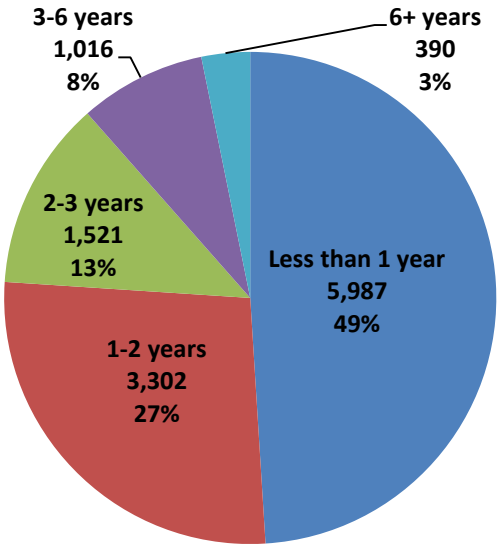


Of the children in care on June 30, 2016, 49 percent were in care for less than one year, while 11 percent were in care for more than 3 years.

[3] Of the 1,474 children categorized as living with their own parents, DHHS included 528 children who are the siblings of removed children but not in the custody of DHHS. DHHS is working to remove these children from future reporting.

Figure 3. Length of Stay in Care of Children in Custody on June 30, 2016

n=12,216



As shown in Table 2, the most common exit from foster care during ISEP 10 was to reunification, with 51 percent of children (1,718) exiting in that manner. Another 21 percent of children (711) exited to adoption. Six percent of exits (211) were to emancipation and another six percent (198) were to guardianship. Twenty-seven children ran away from care and four children died while in care during the reporting period.

Table 2. Exits from Care by Exit Type, January 1, 2016 to June 30, 2016

Exit Type	Count	Percent
Reunification	1,718	51%
Adoption	711	21%
Emancipation	211	6%
Guardianship	198	6%
Living with relatives	41	1%
Transfer to another agency	31	1%
Runaway	27	1%
Death of a child[4]	4	0%
No match found[5]	407	12%
Total	**3,348**	**100.0%**

Note: Percentages may not add to one hundred due to rounding.

As Table 3 demonstrates, of the children in custody on June 30, 2016, the majority (8,419 or 69 percent) had reunification as a goal. For the remaining children, 2,241 (18 percent) had a goal of adoption, 908 (7 percent) had a goal of APPLA,[6] 458 (4 percent) had a goal of guardianship, and 96 (1 percent) had placement with a relative as their permanency goal. There were 94 children (1 percent) with missing goal information.

Table 3. Federal Permanency Goals for Children in Custody as of June 30, 2016[7]

Federal Permanency Goal	Count	Percent
Reunification	8,419	69%
Adoption	2,241	18%
APPLA	908	7%
Guardianship	458	4%
Relative	96	1%
Missing	94	1%
Total	**12,216**	**100%**

[4] The monitors verified that none of these four children died as a result of maltreatment in care.
[5] The data on children's exit type is "no match found" when DHHS' data system does not find a matching code. DHHS is examining its coding in MiSACWIS to ensure that exit types can be identified and reported in the future.
[6] Another Planned Permanent Living Arrangement (APPLA) is an allowable federal permanency goal reserved for youth age 16 and older who will exit foster care without having achieved permanency through reunification, adoption, guardianship or permanent placement with a relative. APPLA is the least preferable permanency goal as it does not create a permanent, legal relationship between the youth exiting foster care and the family with whom they are living.
[7] Children with a federal goal of APPLA and APPLA-E are pooled together for the "APPLA" row.

Organizational Capacity

Caseloads and Supervision

The ISEP sets forth caseload standards for staff and supervisors performing critical child welfare functions. The ISEP states that caseload compliance will be measured by taking the average of three data reports each reporting period, prepared on the last work day of February, April, June, August, October and December. For ISEP 10, caseload counts from February 29th, April 29th and June 30th 2016 were utilized to determine compliance.

Each caseload report contained a number of improperly assigned cases: 773 in February, 706 in April and 707 in June. These improperly assigned cases were excluded from compliance calculations for ISEP 10. However, moving forward, DHHS has committed to the monitors it will manually review caseload data and ensure improperly assigned cases are identified and corrected before submitting reports to the monitoring team. In future periods, the monitoring team will count any staff with multiple improperly assigned cases as noncompliant.

Foster Care Caseloads (6.24)

The ISEP established the foster care caseload standard at no more than 15 children for each full-time foster care worker, public and private, engaged solely in foster care work. Staff who perform foster care work as well as other functions are held to a pro-rated standard. The ISEP requires that 95 percent of staff engaged in foster care work meet the caseload standard. DHHS averaged 88.5 percent of staff, not yet meeting the standard during ISEP 10.

Adoption Caseloads (6.25)

The ISEP established the adoption caseload standard at no more than 15 children for each full-time staff engaged solely in adoption work. Staff who perform adoption work as well as other functions are held to a pro-rated standard. The ISEP requires that 95 percent of staff engaged in adoption work meet the caseload standard. For ISEP 10, DHHS averaged 69.3 percent of staff, falling short of the standard.

Purchase of Service Caseloads (6.28)

Purchase of Service (POS) work comprises the support and oversight that DHHS staff provide with respect to foster care and adoption child welfare cases assigned to the private sector. The ISEP established the full-time POS standard at 90 cases. However, there are some DHHS staff who are assigned a mix of POS and other work, including licensing, foster care, and adoption. For those staff, the standard of 90 POS cases is pro-rated based on their other responsibilities.

DHHS committed that 95 percent of staff engaged in POS work would meet the ISEP standard of 90 cases. For ISEP 10, DHHS averaged 96.2 percent of POS staff, exceeding the standard. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Licensing Caseloads (6.29)

The ISEP established the licensing caseload standard at no more than 30 licensed foster homes or homes pending licensure for each full-time staff engaged solely in licensing work. Staff who perform licensing work as well as other functions are held to a pro-rated standard. The ISEP requires that 95 percent of staff engaged in licensing work meet the caseload standard. DHHS averaged 96.5 percent of staff, exceeding the standard in ISEP 10. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Investigations Caseloads (6.26)

The ISEP established the investigations caseload standard at no more than 12 open investigations for each full-time staff engaged solely in investigations. Staff who perform investigations work as well as other functions are held to a pro-rated standard. The ISEP requires that 95 percent of staff engaged in CPS investigations work meet the caseload standard. For ISEP 10, DHHS averaged 92.8 percent of staff, coming very close to, but not quite meeting the standard.

Children's Protective Services (CPS) Ongoing Caseloads (6.27)

The ISEP established the CPS ongoing services caseload at no more than 17 families for each full-time staff engaged solely in CPS ongoing services. Staff who perform CPS ongoing work as well as other functions are held to a pro-rated standard. The ISEP requires that 95 percent of staff engaged in CPS ongoing work meet the caseload standard. DHHS averaged 91.5 percent of staff meeting the standard in ISEP 10, coming very close to, but not quite meeting the established standard.

Supervisor Caseloads (6.23)

The ISEP established a standard of no more than five caseload-carrying staff for each full-time foster care, CPS, POS, and licensing supervisor. An employee of DHHS or a private child placing agency (CPA) who is non-caseload carrying counts as 0.5 of a worker, and administrative and technical support staff who support the supervisor's unit are not counted toward the worker-to-supervisor ratio. In addition, the methodology requires accounting for the practice among some of the private agencies of assigning both supervisory and direct caseload responsibilities

to the same person, which requires pro-rating both supervisory and caseload performance for these hybrid supervisors.

DHHS committed that 95 percent of supervisors would meet the ISEP caseload standard. During ISEP 10, DHHS averaged 80.7 percent of staff, not meeting the standard for supervisors.

Staff Training

DHHS committed to ensure that public and private agency staff serving Michigan's at-risk children and families receive adequate training in the practice area to which they are assigned. For newly hired staff who will be carrying caseloads, this training is provided by the DHHS Child Welfare Training Institute and is referred to as pre-service training. For staff who are assigned to licensing cases, the training is conducted by the DHHS DCWL and, as approved by the Monitors in 2009, consists of one segment on certification training and another on complaint training.

Licensing Worker Qualifications and Training (6.4)

DHHS agreed in the ISEP to continue to implement the training plan that was approved by the monitors in March 2009 regarding licensing workers. DHHS submitted documentation to the monitors that demonstrated that of the 455 staff who perform licensing activities, 453 (99.6 percent) were compliant with the required training. DHHS exceeded the agreed upon designated performance standard of 95 percent for this ISEP provision. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Caseload Progressions for New Employees (5.1)

The ISEP requires 90 percent of workers who will be assigned CPS cases to complete four weeks of pre-service training prior to any case assignment. At that point, five cases may be assigned, with the understanding that none of these cases involve an investigation with a child under the age of eight or who cannot communicate. Final caseload assignment is made after the successful completion of training, at nine weeks. For foster care and adoption workers, three training cases may be assigned on or after the first day of pre-service training, then up to five cases may be assigned after completion of the third week of the pre-service training, and a full caseload may be assigned after successful completion of the ninth week of pre-service training.

DHHS provided information on all staff hired during the period that included when they began and completed their training. The monitoring team verified workers' progression of caseload assignments against the caseload reports. According to documentation that DHHS submitted, there were 478 new CPS, foster care and adoption staff hired during ISEP 10 who are subject to this provision. Of the 478 staff, 444 were compliant with the caseload progression standard and

34 staff were not compliant. Therefore, DHHS exceeded the Performance Standard with a compliance percentage of 92.9 percent. *Per the ISEP, compliance during this period makes the commitment eligible for immediate exit.*

Accountability

Outcomes

Pursuant to the ISEP, DHHS agreed to meet federal outcome standards regarding safety and permanency for children. The ISEP adopts the outcome methodologies developed by the federal government, including two safety measures from Round Two of the federal Child and Family Services Reviews (CFSR) and five permanency measures from CFSR Round Three. Performance is calculated for DHHS by the University of Michigan based on Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS) files produced by DHHS. For ISEP 10, it was agreed that the time period for all of the metrics would be FFY2016, which commenced on October 1, 2015 and concluded on September 30, 2016.

Safety Outcomes (6.1, 6.2)

The first child safety standard selected by the parties is designed to measure how well the child welfare system protects children from repeated incidents of abuse or neglect. DHHS committed to ensure that of all children who were victims of a substantiated or indicated maltreatment allegation during the first six months of the applicable federal reporting period, at least 94.6 percent were not victims of another substantiated or indicated maltreatment allegation within a six-month period. The monitoring team did not receive Michigan's performance calculations on this outcome, and will therefore initiate verification and reporting for ISEP 11.

The second child safety standard selected by the parties focuses on keeping children placed in foster care safe. DHHS committed to ensure that of all children in foster care during the applicable federal reporting period, at least 99.68 percent were not victims of substantiated or indicated maltreatment by a foster parent or facility staff member. DHHS submitted an inquiry to the Administration of Children and Families (ACF) requesting clarification regarding the syntax used for Round 2 Maltreatment in Care and whether youth age 18 and older are excluded from calculations. In mid-May 2017 DHHS relayed ACF's answer to the monitoring team which will be used to verify and report on this outcome in ISEP 11.

Permanency Outcomes (5.8, 5.9, 5.10, 5.11, 6.3)

Michigan's performance on the five permanency metrics, as reported by the University of Michigan and verified by the monitoring team, is reflected in the chart below. To verify the calculations, the monitoring team used software code provided by the University of Michigan. DHHS met the ISEP standards for four of the five permanency outcome measures, Permanency Indicator 2 (5.8), Permanency Indicator 3 (5.9), Permanency Indicator 4 (5.10) and Permanency Indicator 5 (5.11). *Per the ISEP, compliance during this period makes all four commitments eligible for rolling exit.* DHHS did not meet the ISEP standard for Permanency Indicator 1 (6.3).

Table 4. Michigan Performance on Permanency Outcomes

Measure	ISEP Standard	State Performance	12-month Period
Indicator 1 - Permanency in 12 Months: Of all children who enter foster care in a 12-month period, what percent are discharged to permanency within 12 months of entering foster care?	≥40.5%	28.3%	10/1/2013 – 9/30/2014
Indicator 2 - Permanency in 12 Months: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) between 12 and 23 months, what percent discharged from foster care to permanency within 12 months of the first day of the period?	≥43.6%	48.2%	10/1/2015 – 9/30/2016
Indicator 3 - Permanency in 12 Months: Of all children in foster care on the first day of a 12-month period who had been in foster care (in that episode) for 24 months or more, what percent discharged to permanency within 12 months of the first day?	≥30.3%	46.3%	10/1/2015 – 9/30/2016
Indicator 4 - Re-entry in 12 Months: Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percent re-enter foster care within 12 months of their discharge?	≤8.3%	2.6%	10/1/2013 – 9/30/2014
Indicator 5 - Placement Stability: Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?	≤4.12	3.307	10/1/2015 – 9/30/2016

Contract Oversight

Contract Evaluations (5.12)

The ISEP requires DHHS to conduct contract evaluations of all Child Caring Institutions (CCIs) and Child Placing Agencies (CPAs), including: an annual inspection of each CPA, an annual visit to a random sample of CPA foster homes, and an annual unannounced inspection of each CCI.

DCWL is funded for 19 licensing consultants to perform consolidated monitoring activities including annual visits and investigations for the CPAs and CCIs. There are also eight field analysts who conduct safety visits to foster homes and unlicensed relatives. Two area managers supervise the licensing consultants and field analysts.

DCWL completed 54 renewal and interim inspections of contracted CPAs during ISEP 10. Forty-eight agencies required a corrective action plan (CAP) to remediate contract and/or rule non-compliance. One CPA received a third provisional license status based on repeat violations, one CPA was recommended for license revocation, and one CPA closed.

Field analysts visited 160 foster homes and 49 unlicensed relative homes affiliated with 45 of the 54 agencies. Nine agencies did not have foster or unlicensed relative homes. The monitoring team reviewed all 54 interim and renewal reports, as well as analyst reports for the 45 agencies with foster and unlicensed relative homes. The monitoring team found that 20 of the 45 agencies had at least one home with a health/safety concern identified by DHHS.[8]

During ISEP 10, DCWL conducted 62 special investigations of CPAs for 191 potential rule violations in 38 agencies. Ninety-two rule violations were established (48 percent). Thirty-one CAPs were required as a result of the rule violations, with 30 having been submitted. In one instance, a staff person was disciplined, and for another agency a provisional license was recommended.

During ISEP 10, DCWL completed 46 unannounced renewal or interim inspections on contracted CCIs. Twenty-seven of the inspections were renewals and 19 were interim inspections. DHHS reports that 40 inspections required a CAP and one inspection resulted in a first provisional license recommendation based on the high number and repetition of certain violations.

DCWL conducted 261 investigations in 63 CCIs during the period, looking into 418 potential rule violations. One hundred ninety of these rule violations were established (45.5 percent). The monitoring team found that violations were most commonly cited for instances where staff failed to appropriately supervise residents (51 violations) and for the use of improper, unnecessary or injurious restraints (50 violations). Sixty-six of the investigations involved youth receiving injuries, including eight instances where youth received broken bones as the result of

[8] Examples of concerns included: homes lacking safety-approved cribs or children's beds; homes not having appropriate bedroom egress; unsafe water for drinking and bathing; and a cluttered home to the point that normal movement was impeded. Four agencies had at least one unlicensed relative with a health/safety issue, nine agencies had at least one regular foster home with a health/safety issue, and seven agencies had at least one foster and relative home with a health/safety issue. There was documentation in 14 of the 20 consultants' interim or renewal reports indicating that health and safety concerns were resolved, while four agency reports only had partial documentation of remediation, and two agency reports did not document resolution of the issues.

restraints[9]. CAPs were required in 100 of the investigations, 32 staff were terminated as a result of investigation findings, and one facility was recommended for license revocation due to the high number and seriousness of the violations.

DHHS places children in facilities that either receive or do not receive Community Mental Health (CMH) funding. Unique to CCIs that contract with community mental health services programs or prepaid inpatient health plans is a provision within Public Act 116 (722.112). For these CCIs only, if a child is injured during the course of implementing a restraint, even if DCWL determines the restraint was implemented in accordance with all other licensing regulations, the CCI licensee must be cited as noncompliant with Act 116, section 722.112 (d) as Michigan law prohibits any injury no matter how the child was injured. That measure of protection does not exist for children placed in CCIs that do not receive CMH funding. Essentially, identical injuries can be incurred by children as the result of identical restraints or seclusions, but the outcome of the licensing investigation can be different depending on the funding source of the CCI. The monitoring team has concerns about this inconsistency.

Seclusion in Contract Agencies (6.35)

The ISEP requires that all uses of seclusion or isolation in CCIs be reported to DCWL for necessary action. The licensing rules require that any room utilized for seclusion have the prior approval of the licensing consultant. The rules also define when seclusion may be utilized and the type of documentation required, which is dependent on the length of time a child is secluded. Seclusion and isolation are monitored by DCWL during annual and renewal on-site inspections, and are investigated when noncompliance is alleged. All substantiated violations of seclusion and isolation and any CAPs are documented in the licensing information system. Repeat violations can adversely affect an agency's license. DHHS reported no violations for failure to report the use of seclusion or isolation in any CCI, and is compliant with this commitment. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Psychotropic Medication as a Method of Discipline (5.14)

The ISEP requires that psychotropic medication should not be utilized as a method of discipline nor be utilized in place of psychological or behavioral interventions that a child requires. DCWL

[9] Licensing investigations for seven of the restraints that resulted in children's broken bones concluded that there was no CCI rule violation. In one restraint, DCWL determined that the staff violated procedure and the CCI terminated the staff's employment.

monitors improper use of psychotropic medication according to CCI rules, policy, and contract obligations.

During ISEP 10, DHHS reports that no violations or allegations of noncompliance with this ISEP commitment were found when conducting 49 unannounced renewal or interim visits of contracted CCIs. Each visit included a sampling of case reviews of children who are currently in placement or had been in placement since the previous inspection. DCWL also conducted 261 special investigations involving 63 contracted CCIs during this period and found no violations regarding improper use of psychotropic medications as a method of discipline. DHHS was compliant with this standard during ISEP 10.

Quality Service Reviews

DHHS implemented the Quality Service Review (QSR) in 2013 to provide a comprehensive view of case practice, identifying strengths as well as opportunities for improvement in how children and their families benefit from services. Each review focuses on an identified county or counties and includes in-depth case reviews, as well as focus groups and surveys.

DHHS conducted two QSRs in nine counties during ISEP 10. The monitoring team participated in QSRs in Lapeer/Tuscola/Port Huron counties in April 2016 and in Berrien/Van Buren counties in June 2016. Monitoring team members observed and participated in the focus groups, case reviews, case scoring and presentations to administrators.

DHHS chose a randomly selected sample of open cases for review during each QSR. Cases were graded on 21 indicators covering different areas of case practice and the status of the child and family. Information was obtained through in-depth interviews with case participants including the child, parents or legal guardians, current caregiver, caseworker, teacher, therapist, service providers, and others having a significant role in the child or family's life. A six point rating scale was used to determine whether performance on a given indicator was acceptable. Any indicator scored at four or higher was determined acceptable, while any indicator scored at three or lower was determined to be unacceptable.

The parties agreed that four commitments: Assessments and Service Plans, Content (6.33); Provision of Services (6.34); Education, Appropriate Education (6.36); and Education, Continuity (6.38), would be measured through the QSR case reviews.

Assessments, Service Plans, and Provision of Services (6.33, 6.34)

DHHS agreed to develop a comprehensive written assessment of a family's strengths and needs, designed to inform decision making about services and permanency planning. The plans must be signed by the child's caseworker, the caseworker's supervisor, the parents, and the

children, if age appropriate. If a parent or child is unavailable or declines to sign the service plan, DHHS must identify steps to secure their participation in accepting services.

The written service plan must include:

- The child's assigned permanency goal;
- Steps that DHHS, CPAs when applicable, other service providers, parents, and foster parents will take together to address the issues that led to the child's placement in foster care and that must be resolved in order to achieve permanency;
- Services that will be provided to children, parents, and foster parents, including who will provide the services and when they will be initiated;
- Actions that caseworkers will take to help children, parents, and foster parents connect to, engage with, and make good use of services; and
- Objectives that are attainable and measurable, with expected timeframes for achievement.

DHHS agreed that the services identified in the service plan will be made available in a timely and appropriate manner and to monitor services to ensure that they have the intended effect. DHHS also agreed to identify appropriate, accessible, and individually compatible services; to assist with transportation; and to identify and resolve barriers that may impede children, parents, and foster parents from making effective use of services. Finally, DHHS committed to amend the service plan when services are not provided or do not appear to be effective.

The ISEP performance standard regarding assessment and service plans (6.33) requires that 90 percent of assessments and services plans shall be of sufficient breadth and quality to usefully inform case planning. DHHS reviewed a total of 22 cases during the two QSRs conducted during ISEP 10. Of these 22 cases, DHHS reported that 18 (81.8 percent) were rated as having acceptable assessments and services plans. DHHS therefore did not meet the standard required by the ISEP.

DHHS reported that 17 (77.3 percent) cases reviewed during the two QSRs were rated as acceptable for provision of services, not meeting the standard for this commitment. The parties did not identify a performance standard for provision 6.34, which requires the timely and appropriate identification of, and provision of, services to children and families. The monitors request that the parties agree on a performance standard for 6.34 by September 1, 2017. Absent such agreement, and in light of the fact that the use of the QSR as a performance instrument is subject to the approval of the monitors, the monitors will adopt a standard.

Education, Appropriate for Child (6.36)

The ISEP requires DHHS to take reasonable steps to ensure that school-aged foster children receive an education appropriate to their needs. DHHS reported 12 of the 22 cases reviewed during the two QSRs were applicable to this commitment. The 12 cases were rated by looking at the child's school attendance, grade level, reading level, engagement in instructional activities, and progress towards meeting requirements for promotion and course completion leading to a high school diploma, GED, or preparation for employment. DHHS reported that 9 of the 12 (75 percent) cases were rated as acceptable for this commitment. The parties did not identify a performance standard for provision 6.36. The monitors request that the parties agree on a performance standard for 6.34 by September 1, 2017. Absent such agreement, and in light of the fact that the use of the QSR as a performance instrument is subject to the approval of the monitors, the monitors will adopt a standard.

Education, Continuity (6.38)

The ISEP also requires that DHHS make reasonable efforts to ensure the continuity of a child's educational experience by keeping the child in a familiar or current school or neighborhood, when this is in the child's best interests and feasible, and by limiting the number of school changes the child experiences. Of the 22 cases DHHS reviewed during the ISEP 10 QSRs, 15 were deemed applicable to this commitment. Cases were scored by the degree to which the child's daily learning arrangement was stable and free from risk of disruption. DHHS reported that 13 of the 15 (86.7 percent) cases were rated as acceptable for this commitment. The parties did not identify a performance standard for provision 6.38. The monitors request that the parties agree on a performance standard for 6.34 by September 1, 2017. Absent such agreement, and in light of the fact that the use of the QSR as a performance instrument is subject to the approval of the monitors, the monitors will adopt a standard.

Data Reporting

Generation of Data (6.57)

DHHS produced data from MiSACWIS to demonstrate performance on commitments in ISEP 10 and to document baseline populations and samples for QAPs. DHHS also submitted "cohort" data, which described entries and exits from foster care during the period, the number of children served during the period, and the number of children in care at the beginning and end of the period. The monitoring team analyzed the information to verify its quality, assessed the methodology used to compute performance for each metric, and attempted to replicate the performance calculations made by DHHS.

The monitoring team encountered several data issues in ISEP 10 that delayed the analysis and verification work necessary to complete this report. The methods, initial descriptions of the data, and initial descriptions of the calculations provided by DHHS often did not provide enough information for the monitoring team to verify performance, and gave way to extensive exchanges between DHHS and the monitoring team. In a few situations, the monitoring team and DHHS also differed on the initial calculation methodology, and those too were discussed and addressed as needed. Data quality issues undermined efforts by the monitoring team to verify performance in certain areas, and were also discussed in an effort to achieve accuracy and resolution. The monitoring team worked through many issues with DHHS by email, phone, memos, and in-person meetings. Certainly, some issues should be expected with the onset of both a new agreement and the inauguration of reporting from a complex, new child welfare data information system. The pervasiveness of the data challenges identified during the verification process in preparation of this report led the monitoring team and DHHS to begin development of a new tool – an ISEP Metrics Plan – which is currently underway and will set forth in detail the methods, descriptions of the data and descriptions of the calculations to be supplied by DHHS to the monitoring team to assess performance on many of the ISEP commitments.

The data issues that surfaced for ISEP 10 took several forms:

1. **Duplicate and overlapping entries.** Some of DHHS' submissions contained two or more entries for the same child when only a single entry should exist. In some instances, the data showed children experiencing overlapping spells (i.e. two different removal dates without an exit in between). In other instances, the submission listed a child twice with the same removal date, but with only one listing having an exit date. In other cases, submissions included the same information for the same child. Finally, some entries listed an exit date with a re-entry the same day or the next day ("continuous spells"). Continuous spells, overlapping spells, two entries without a corresponding exit, and duplicates with the same child information were present in the entry, exit, and during cohorts of each of the ISEP 10 cohort data submissions. These types of duplicate rows also appeared in data submissions for commitments 6.8, 6.20, 6.21, and 6.47. Duplicate entries in the initial data submissions delayed approval of QAPs for commitments 5.6 and 6.57. Duplicate entries also appeared in the ISEP 10 caseload data. Duplicate caseworker entries caused delays in verifying the total number of caseworkers, the caseloads of those workers, and their compliance, and DHHS has since that time addressed this issue in the caseload data.

2. **Kin licensure as placement change.** In some files submitted by DHHS to the monitors, the data recorded placement changes when kin caregivers received a foster care license,

even though there was no placement change - the children stayed with the same caregivers in the same locations. Several commitments measure performance when children either enter care or change placements in care. For example, commitment 6.39, worker-child visits, necessitates more frequent worker-child visits for the first two months after a child with a goal of reunification experiences a placement change or an initial removal. Similarly, commitment 6.37, education attendance, requires school-aged foster children be enrolled within five days of initial placement or a placement change.

3. **Data mismatches.** As part of its verification process, the monitoring team matches data used for a performance metric with other data submitted by DHHS. These matches take place most often between performance data and the "cohort" data described above. In many instances, the data submitted for a commitment did not match with data in the cohorts and did not have an explanation for the mismatch. For example, the data for commitment 6.40, worker-parent visits, omitted 2,972 children in the during cohort with a goal of reunification. The monitoring team believes this occurred in part because of issues in the children's case goal data, as many of these children were listed as legally free. The initial data submitted for commitment 6.43, medical and mental health examinations upon entry, did not include many of the children in the cohort "entries" file (DHHS later clarified this issue). The team also discovered major differences between the cohort data listing children in foster care on the last day of ISEP 9 (December 31, 2015) and on the first day of ISEP 10 (January 1, 2016). These discrepancies occurred in part due to the Department's efforts to improve cohort data quality but were not discussed in the written materials accompanying the submissions (DHHS later clarified several of these issues). The monitoring team reviewed and approved a new method proposed by DHHS for constructing cohort data. That method will be piloted in ISEP 11 and implemented in ISEP 12.

   Data mismatches also caused delays when verifying the populations, the samples, and the sample sizes for QAPs. For example, when attempting to verify the population for the QAP for commitment 5.7, support for transitioning to adulthood, the monitoring team identified a larger 5.7 population in the end of period cohort than DHHS did in their initial submission (DHHS resubmitted data that the monitoring team later verified). This issue also affected the QAP for commitment 6.16, relative foster parents.

4. **Structure of the data.** Some data files had structures that did not match the commitments or had complex structures that were not explained fully in the submission. Data on the use of emergency or temporary placements (commitments 6.13 and 6.14), for example, listed a child's most recent stay as the child's *first* stay. For children with multiple placements, the most recent stay is the *last* stay. Since the

requirements for this commitment change from the first stay to successive stays, the order of the data impacted the performance calculation. In some submissions, such as visitation data, complex data were not described such that the monitoring team could verify performance. For example, a data submission for commitment 6.39 included an "event row number" field that was not adequately defined and applied inconsistently in some places. The data submitted for commitment 6.8, related to children's placement in jail, correctional and detention facilities, had the individual child as the unit of analysis instead of the placement episode.

5. **Missing, unavailable, and unknown data**. Missing and unavailable data took several forms. In some instances, data submissions included fields that did not have data for some children. The data for commitment 6.9 concerning placement within 75 miles from home, for example, had a field for distance from location of removal that contained no information for 416 children, or 3.7 percent of all children and youth under 18 years of age. Cohort data for the children served during the period under review (PUR) had no federal goal codes for 178 children (1 percent of children served). Cohort data for children discharged during the PUR did not include the exit type for 413 children (12 percent of exits during the PUR). The initial ISEP 10 cohort data submission had a large percentage of missing data in the "Hispanic flag" field for all five cohorts. DHHS later clarified this issue.

   In other instances, submissions did not include information required to calculate some metrics properly. Commitment 6.21 concerning the timeliness of investigations, for example, allows for extensions for three reasons, but the data did not have a field identifying the reasons for extensions. In addition, the submission contained only the last extension request instead of all extension requests. For commitment 6.52, medical care and coverage subsequent placement, the data included a "not applicable" value in 1,886 cases for unknown reasons. Some data, such as juvenile delinquency disposition dates, are not available electronically and require manual retrieval.

   The initial data submission for commitment 6.40, worker-parent visits, did not provide the dates that worker-parent visits occurred, identifying information for the workers who conducted the visits, or the locations of the visits. The data submission for commitment 6.41, parent child visits, did not include an "exceptions" variable to explain the absence of parent-child visits during the PUR for children with a goal of reunification. In the ISEP 10 caseload data submissions, DHHS did not include numerators or denominators necessary to verify caseworker and supervisor compliance calculations.

Unavailable data fields caused delays when verifying the populations and sample sizes for QAPs. The initial data submitted for commitment 5.7 QAP, concerning APPLA goals, for example, did not include a variable to identify youth with a goal of adoption who had an identified family. The data for the 6.10 QAP, separation of siblings, did not include a "sibling ID" variable in the population data. The QAP data for commitment 6.37, education attendance, omitted children who entered care prior to the PUR and moved during the PUR—data needed to identify properly the 6.37 population. The initial data submission for the 6.45 and 6.46 QAPs, concerning immunizations, did not include the file used to draw the population.

6. **Incorrectly labeled data.** In a small number of situations, the submission contained incorrectly labeled data. For example, data for commitment 6.20 was incorrectly labeled and submitted for commitment 6.21, a related, but different commitment. In other cases, the description of a data field did not match the content of the field. The data for commitment 6.39 included an "event-contact date" variable, described as the date a contact or removal/placement change occurred. After analyzing the data and conferring with DHHS, the monitoring team learned that the event-contact date variable was used to summarize required monthly visits that DHHS staff made.

7. **Out-of-range data.** Several submissions included data reflecting events that occurred either prior to or after the PUR, often without an explanation for why these data were included. For some submissions, the out-of-range data included only a small number of cases, but these occurrences still required time to explore why the data were included, whether the calculation method or data extraction procedure created issues for data within the range of the PUR, and in some cases to adjust the performance measure. The data for commitment 6.44 concerning dental examinations, for example, included 35 children under the age of four as of the due date of a dental appointment, though the ISEP excludes these children from the commitment. DHHS rectified this in a subsequent data submission. In other cases, submissions included large amounts of out-of-range data. In a submission for commitment 6.52, providing a medical insurance card to a new provider, the submission included 979 entries that indicated that new caregivers received medical insurance cards before the replacements occurred, including hundreds that received the card weeks or months before the replacement occurred. DHHS explained later why this occurred. A data submission for commitment 6.39 included 10,176 worker-child visits that occurred on dates outside of the PUR without an explanation. DHHS later explained why this occurred. Out of range data also delayed verification of the populations, samples, and sample sizes for QAPs. The QAP for commitment 5.6, family team meetings, included three rows that referred to children

not 16 years old at discharge. The initial QAP data for commitment 6.16, relative foster parents, included 187 children that had placement start dates outside of the PUR (in some cases over a year before the PUR) without explanation.

8. **Calculation methods.** As should be expected in a new agreement, several of the commitments leave room to interpret how to calculate a performance metric. In some situations, the monitoring team and DHHS simply needed to reach consensus concerning the most appropriate way to measure performance. For example, in calculating length of stay in emergency or temporary placements (commitments 6.13 and 6.14), DHHS counted the placement end date of some detention episodes as June 30 (the last day of the PUR), though there was an indicator that the child was still detained beyond the end of the period. In other episodes, DHHS listed a placement end date after June 30th, but calculated the length of stay in detention as of June 30th.

9. **Re-submissions.** DHHS needed to resubmit data and/or performance calculations for many of the commitments, in some instances more than once. Data for the following commitments were resubmitted at least once: 5.7, 5.10, 6.3, 6.8, 6.9, 6.13, 6.14, 6.20, 6.21, 6.23-6.29 (caseloads), 6.39, 6.40, 6.41, 6.43, 6.44, 6.47, 6.51, 6.52, and 6.57 (cohorts).

The monitors expected to be able to review data submissions from DHHS and follow the descriptions in DHHS cover memos to replicate DHHS's results. Due to the issues cited above, this rarely occurred in initial submissions and sometimes not in resubmissions. In some situations, the mismatch involved a small number of cases, while in others, performance differed substantially or could not be calculated based on the information submitted by DHHS. While the monitoring team worked through many issues with DHHS, data issues caused delays and prevented reporting on several other commitments in ISEP 10.

With DHHS, the monitoring team developed a multi-pronged plan to address these issues. By ISEP 12, DHHS plans to transition to an AFCARS-based methodology to produce cohort data, which should provide more consistent and higher quality cohort data.[10] The monitoring team reviewed and approved this methodology. The aforementioned Metrics Plan is expected to be developed to guide all parties to a common understanding of the methods used to calculate performance on ISEP commitments. DHHS indicates the agency will continue to work with experts at the University of Michigan to assist in its reporting efforts to the monitoring team.

[10] AFCARS stands for the federal Adoption and Foster Care Analysis Reporting System, which uses standardized data sets submitted by states to the federal government every six months.

Permanency

Developing Placement Resources for Children

Foster Home Array (6.5)

When it becomes necessary for a child to be removed from a caregiver due to abuse or neglect, DHHS has the responsibility to ensure that the child is placed in the least restrictive, appropriate, safe placement. Through the ISEP, DHHS is committed to maintain a sufficient number and array of foster homes to serve the needs of the foster care population. This includes potential placements for adolescents, sibling groups and children with disabilities. In order to ensure it maintains an adequate array of foster homes, DHHS requires the development of Adoptive and Foster Parent Recruitment and Retention (AFPRR) plans for each county, informed by specific information based on county needs. The plans include target numbers of homes to be developed, the recruitment and retention efforts that will be utilized, timeframes for activities, a proposed budget and who will be responsible for the implementation of the plans.

Each of the five DHHS Business Service Centers (BSCs) is required to review and roll up the information in the AFPRR plans from their counties and submit one plan. According to DHHS, each plan is analyzed by the Office of Child Welfare Policy and Planning, which sets monthly licensing targets and assists the counties and BSCs with monitoring progress.

As per the ISEP, recruitment plans and targets are to be developed in consultation and with input from the monitors. The ISEP was approved in February 2016 after DHHS had already developed and implemented the AFPPR recruitment plans for FY2016. Since the first recruitment plans developed under the ISEP were finalized in consultation with the monitors for FY2017, the monitors will evaluate implementation in ISEP 11.

Placement Process (6.6)

The ISEP requires that each county develop a placement process that ensures the best match for a child irrespective of whether the foster home is DHHS or private agency foster care (PAFC) provided.

DHHS reported that the Child Placing Network (CPN) is now contained within the MiSACWIS data system. The CPN system enables DHHS to conduct a statewide search and provides a list of foster homes that meet all placement selection criteria for a child who requires a foster home placement. DHHS reported that its local offices and private agencies are expected to update foster home provider information on an ongoing basis to ensure current and accurate information is in the system.

Prior to ISEP 10, DHHS convened a work group of public and private agency leaders to address systemic barriers to effective placement planning efforts. The group identified the need to increase attention to the specific tasks and activities necessary in county public/private collaborative relationships. Based on the input from the group, DHHS developed "County Collaboration and Placement Planning Guidelines" and required that DHHS county offices and respective private child placing agency partners develop plans to ensure collaborative efforts to recruit and utilize available licensed foster homes.

The monitoring team reviewed the plans and found that there continue to be counties that utilize a rotational system of foster home selection, not the CPN. In one county the CPN matching function for locating a placement was not functioning. Some counties continue to consider funding source as a priority in considering placement choices. Home selection in these counties was not inclusive of all available homes, which is inconsistent with this provision of the ISEP.

Relative Placements (6.16)

DHHS relied on relative caretakers to serve as placement resources for 34 percent of children in its custody at the conclusion of ISEP 10. This, in general, frequently represents good social work practice as it usually reduces trauma and increases the likelihood of placement stability for children. The decision to place a child in an unlicensed relative home should never compromise a child's safety or access to resources. To ensure the safety of children who are placed in relative homes that have not previously been licensed as foster parents, DHHS agreed to take the following actions:

- Prior to placement, DHHS will visit the home to determine that it is safe;
- Within 72 hours following placement, DHHS will check law enforcement and central registry record records for all adults residing in the home; and
- Within 30 days of placement, DHHS will complete a home study determining whether the relative should, upon completion of training and submission of any other required documents, be licensed as a foster parent.

The parties agreed that this provision would be measured through a QAP, until such time that MiSACWIS can produce data to evaluate DHHS' performance. The monitors and the Department's CQI team jointly approved the QAP review tool and the associated reviewer training. The population included in this review consisted of all children in foster care who were placed with an unlicensed relative during the reporting period, a total of 1,569 children. DHHS utilized a statistically valid random sample of 309 children, stratified by county. The sample was based on a five percent margin of error and a 95 percent confidence level. Of the 309 cases,

138 were determined to be compliant and 171 were not, resulting in 44.7 percent compliance, below the designated performance standard of 95 percent.

The monitoring team conducted an independent review of DHHS' results. The review consisted of 75 randomly selected cases that the DCQI unit included in the QAP review. The monitors' review confirmed that DHHS did not meet the designated performance standard. The review revealed in some instances, criminal and child welfare history checks were not completed, were incomplete or were completed late for adults in a home. Children were placed in homes without enough beds, with pack n' plays used in their place for very young children, with unsecured firearms and ammunition, without carbon monoxide detectors and with unresolved substance abuse issues by adults living in the home. Some caregivers expressed the need for financial and daycare support to adequately provide for the children placed in their care and it was not clear from the documents reviewed that service needs were routinely and adequately met. Safety and other placement concerns identified on the initial safety screen were not always rectified by the time the home study was completed up to 30 days later.

Relative Foster Parent Licensing and Placement Standard (6.7, 6.17, 6.18, 6.19)

Consistent with the ISEP, DHHS is required to license at least 85 percent of newly licensed relatives within 180 days of the date a child is placed in the home (6.18). According to data submitted by DHHS for the period under review, DHHS licensed 295 relatives. Of those, 76 (26 percent) were licensed within 180 days of the date of placement, which is below the designated performance standard of 85 percent.

The ISEP requires that at least 80 percent of all relative caregivers must either (a) have submitted a license application to DHHS and not have had a child placed in their home for more than 180 days, or (b) hold a valid license. Exceptions are allowed if the placement was a direct placement by court order into an unlicensed relative home (6.19). On June 30, 2016, DHHS had 3,982 children in placement with 2,510 relative caregivers. Of those 2,510 relative caregivers, only 970 (39 percent) were either licensed or had submitted a license application to DCWL.[11] This level of performance is well below the designated performance standard of 80 percent.

The ISEP states that children in the foster care custody of DHHS shall be placed only in a licensed foster home, a licensed facility, pursuant to an order of the court, or an unlicensed relative with a waiver (6.7). In addition, the ISEP states that relative caregivers will be licensed

[11] A further breakdown of the 970 caregivers indicates that 792 held a license at the end of the period and 178 caregivers had submitted a license application and did not have children placed in their home for more than 180 days.

unless exceptional circumstances exist such that it is in the child's best interest to be placed with the relative despite the relative's desire to forgo licensing (6.17). DHHS was unable to provide information on waivers for relative caregivers during ISEP 10. Therefore, the monitoring team was unable to verify performance for commitments 6.7 or 6.17.

Placement Standards

Placing Siblings Together (6.10)

The ISEP requires DHHS to place siblings together when they enter foster care at or near the same time. Exceptions can be made if placing the siblings together would be harmful to one or more of the siblings, one of the siblings has exceptional needs that can only be met in a specialized program or facility, or the size of the sibling group makes such placement impractical notwithstanding efforts to place the group together. The commitment also requires that if siblings are separated at any time, except for any of the aforementioned reasons, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited. Efforts to place siblings together are to be documented and maintained in the case file and reassessed quarterly.

DHHS and the monitors agreed to measure and evaluate this commitment through two separate QAP reviews. The first QAP would evaluate and review the children who enter placement and the second QAP would evaluate the Department's attempts to reunite the siblings.

The first QAP looked at children who were part of a sibling group who entered care within 30 calendar days of each other during the period and were separated. For ISEP 10, a statistically valid random sample of 299 children was selected from a total population of 1,240 children. The Department's DCQI unit conducted the review. Of the 299 children reviewed, DCQI found that 57 (19.1 percent) had an approved Placement Exception Request. DHHS did not achieve the designated performance standard of 90 percent for this commitment. The monitoring team reviewed a sample of cases assessed by DCQI and confirmed that DHHS did not meet the designated performance standard during ISEP 10.

The population for the second QAP consisted of children who were part of a sibling group and were separated at any time during the review period. For ISEP 10, a statistically valid random sample of 366 children was selected from a total population of 5,592 children. DCQI found that DHHS met the terms of the commitment in 262 cases (71 percent), shy of the designated performance standard of 90 percent, during ISEP 10. The monitoring team reviewed a sample of cases read by DCQI and confirmed that DHHS did not meet the designated performance standard for this commitment.

Placement Proximity from Removal Home (6.9)

The ISEP requires DHHS to place all children within a 75 mile radius of the home from which the child entered custody unless:

- The child's needs are so exceptional that they cannot be met by a family or facility within a 75 mile radius; or
- The child needs replacement and the child's permanency goal is reunification with his or her parents who at the time reside out of the 75 mile radius; or
- The child is to be placed with a relative or sibling out of the 75 mile radius; or
- The child is to be placed in appropriate pre-adoptive home that is out of the 75 mile radius.

Any of the above listed exceptions require the approval of the County Director or, in a designated county, a county-level child welfare administrator. The approving authority is specifically required to certify the circumstances supporting the placement in writing, based upon his or her own examination of the circumstances and the child's needs and best interests.

Of the children in care at the end of the period who were under the age of 18, DHHS was unable to report on distance from home for 3.7 percent of youth. Of the remaining children, DHHS reported it placed 98.3 percent who were under the age of 18 in accordance with the commitment. Even if all of the children DHHS could not provide data on were placed more than 75 miles from their removal address without an allowable exception, DHHS performance would be 94.7 percent.

Number of Children Residing in a Foster Home (6.12)

DHHS committed in the ISEP that no child shall be placed in a foster home if that placement will result in: (1) more than three foster children in that foster home; (2) a total of six children, including the foster family's birth and adopted children; or (3) more than three children under the age of three residing in that foster home. Exceptions to these limitations may be made by the Director of DCWL, on an individual basis documented in the case file, when in the best interest of the child(ren) being placed. This commitment is to be measured through a QAP until MiSACWIS can produce data to measure it.

DHHS has asserted that this commitment only applies to children who are placed in licensed foster homes and that children placed with unlicensed relatives are not subject to the provision. The plaintiffs maintain that the provision applies to all children placed in licensed or unlicensed foster homes. The parties have not been able to resolve this issue, and will seek clarification from the court. For ISEP 10, DHHS did not complete a QAP or provide data on this commitment.

Reviewing Long-Term Institutional Placements (6.15)

The ISEP requires that for DHHS to place a child in a CCI, the placement must be initially approved by the County Director or a county-level child welfare administrator and then reassessed every 90 days. Any placements exceeding 12 months must be approved by the director of Child Welfare Field Operations or a designee. The system is designed to promote a value shared by the parties: that children are placed in the least restrictive and most family-like settings when in their best interest. DHHS reported that as of June 30, 2016, there were 946 children placed in CCIs. However, DHHS was unable to provide data or information on the length of time children were placed in CCIs.

Emergency or Temporary Facilities (6.13, 6.14)

DHHS agreed that no child shall be placed in an emergency or temporary facility for a period in excess of 30 days unless exceptional circumstances exist or for a period in excess of 60 days with no exceptions. During ISEP 10, DHHS did not meet, but came close to meeting, the designated performance standard of 95 percent for this commitment. Of the 204 youth placed in emergency or temporary placements during the period, 92.6 percent were within the length of stay parameters, with 12 youth having a placement that lasted over 60 days and three youth having a placement that lasted over 30 days for which no approval was granted.

Additionally, the ISEP states that no child shall be placed in an emergency or temporary facility more than one time in a 12-month period, unless exceptional circumstances exist and no child experiencing a second emergency or temporary facility placement within one year may remain in an emergency or temporary facility for more than seven days. The indicator requires at least 12 months of placement data, so the monitoring team will report on DHHS' performance for the 12-month period covering ISEP 10 (January – June 2016) and ISEP 11 (July – December 2016) in the ISEP 11 report.

Jail, Correctional, or Detention Facilities (6.8)

DHHS agreed that unless pursuant to a delinquency charge, no child in DHHS custody shall be placed by DHHS in a jail, correctional, or detention facility. The ISEP also requires that a foster child in such a setting without a delinquency charge must be moved to a foster care placement within five days of DHHS becoming aware, unless a court orders otherwise over a DHHS objection. If there is a delinquency charge and the disposition is for the child to return to a foster care placement, the child must be returned to foster care within five days of disposition of that delinquency charge.

Based upon information submitted by DHHS, 143 children resided in a jail or detention facility one or more times during ISEP 10 for a total of 169 placement episodes. DHHS reports that

there were only three instances where a child in DHHS custody was placed in a jail, correctional, or detention facility without an underlying delinquency charge. Review of data provided by DHHS indicates that one youth was court-ordered into a detention placement, and resided there for 20 days, with no objection in the record. A second youth was placed in detention for 30 days without a delinquency charge as an "emergency placement." A third youth was court-ordered into detention, and remained there for seven days, with no objection found in the record. Because DHHS was unable to provide information on whether children placed in a jail or detention facility were returned to a foster care placement within the required timeframe, the monitors cannot assess performance for this commitment for ISEP 10.[12]

Case Planning and Practice

Timeliness of Service Plans (6.31, 6.32)

The ISEP requires that DHHS complete an initial service plan (ISP) within 30 days of a child's entry into foster care (6.31) and then update the service plan at least quarterly thereafter (6.32). The Department reported that of the 3,401 ISPs due during the period, 2,061 (60.6 percent) were completed within 30 days of a child's entry into foster care or Young Adult Voluntary Foster Care (YAVFC). DHHS reported that of the 24,984 updates due during the period, 18,775 (75 percent) were completed at least quarterly. DHHS did not achieve the designated performance standard of 95 percent for either commitment.

Supervisory Oversight (6.30)

Supervisors are to meet at least monthly with each assigned caseworker to review the status and progress of each case on the worker's caseload. Supervisors must review and approve each service plan after having a face-to-face meeting with the worker, which can be the monthly supervisory meeting. DHHS reported that supervisors approved 81 percent of ISPs and 83 percent of updates due during ISEP 10. However, DHHS was unable to report whether the supervisors and workers had a face-to-face meeting before each service plan was approved. Of the monthly meetings between supervisors and their assigned caseworkers, 47,656 of 67,631 (71 percent) were completed timely during the period. DHHS did not achieve the designated performance standard of 95 percent for any portion of this commitment.

[12] DHHS is able to provide the date the child is placed in a foster care placement following release from a jail, correctional or detention facility; however the juvenile justice data system is not connected to the MiSACWIS system. As such, there is no electronic way to know the date that the Judge has verbally ordered the release of the child thereby starting the five calendar day clock. Going forward, this data will be captured through a manual process.

Compliance regarding the content of assessments and service plans required pursuant to the ISEP (6.33) and the required provision of services (6.34) were measured pursuant to the Quality Service Review process and are detailed in the report on page 27.

Caseworker Visitation

DHHS agreed to the following visitation schedules for all open cases with children in the state's custody:

- Caseworkers shall visit all children in custody at least twice in each of the first two months of a child's initial or new placement, and at least once in each following month. Additionally, at least one visit each month shall occur in the placement setting and include a private meeting between the worker and the child.
- Caseworkers shall visit parents of children with a goal of reunification at least twice during the first month of placement, with at least one visit in the parent's home. For subsequent months, visits must occur at least once per month, with at least one contact in each three month period occurring in the parent's place of residence.
- All children with a goal of reunification shall visit their parents at least twice monthly unless specified exceptions exist.
- Siblings in custody who are not placed together shall visit each other at least monthly unless specified exceptions exist.

For ISEP 10, DHHS produced data on worker-child (6.39), worker-parent (6.40), and parent-child (6.41) visits. Due to data quality issues, the monitoring team was unable to verify the state's performance on these commitments, as detailed below. DHHS was unable to produce data on sibling visits (6.42) for the reporting period.

Worker Child Visitation (6.39)

The monitoring team was unable to verify the performance for this commitment. DHHS submitted data for this metric on September 12, 2016; February 7, 2017; and April 20, 2017. The initial 6.39 data submission indicated only that DHHS complied with the commitment in each month, but did not provide details on when and where individual visits occurred. The February data submission included this information, but had a calculation error and required an additional file to verify performance. DHHS resubmitted the visit data and the performance calculations in April 2017, which did not allow sufficient time for the monitoring team to understand variations in the number of required visits in the resubmitted file and other aspects of the calculation methodology prior to the completion of this report.

Worker Parent Visitation (6.40)

The monitoring team was unable to verify the performance for this commitment. DHHS submitted data for this commitment on September 12, 2016. The monitoring team asked for several clarifications concerning how DHHS handled exceptions, situations where parents were unknown, and other situations. After receiving a response and revised data in December 2016, the monitoring team continued verification and raised additional questions in a memo to DHHS on January 13, 2017. The team received answers to these questions in a meeting in Detroit on January 31, 2017, and continued its verification activities. Further analysis of the data shows that there are still issues that require resolution; DHHS is working on these issues.

Parent Child Visitation (6.41)

The monitoring team was unable to verify the performance for this commitment. DHHS submitted data for this commitment in September 2016, and resubmitted data in February 2017. The September data indicate only if DHHS met the visiting commitment, but did not provide the federal goal of the child in care, the dates and locations of parent-child visits, or information on allowed exceptions to the commitment. The monitoring team asked for clarifications on the September data submission in October 2016 and received information and a new summary file in early December 2016. The monitoring team raised additional concerns about the data in January 2017 and received the February 2017 resubmission following a January 2017 in-person meeting. Further analysis of the data shows that there are still issues that require resolution; DHHS is working on these issues.

Safety and Well-Being

Responding to Reports of Abuse and Neglect

Commencement of CPS Investigations (6.20)

DHHS committed to commence investigations of reports of child abuse or neglect within the timeframes required by state law. DHHS reported that during ISEP 10, there were 46,820 complaints that required the commencement of an investigation. Of those, 43,056 (92 percent) were commenced timely. DHHS exceeded the designated performance standard of 85 percent for this commitment. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Completion of CPS Investigations (6.21)

DHHS agreed that all child abuse or neglect investigations would be completed by the worker and submitted to the supervisor within 30 days and then supervisory review and approval

would occur within 14 days of worker completion. During ISEP 10, there were 43,412 investigation reports due. Of those, 35,015 (80.7 percent) were completed timely by CPS workers[13]. Of the 46,002 investigation reports due for supervisory approval during the period, 41,525 were completed timely (90 percent).

The above-referenced data regarding DHHS' compliance on supervisory approval of CPS investigations was derived from a summary report, and the monitoring team was unable to determine how many investigations were completed timely by both the worker and supervisor. However, as only 80.7 percent of reports were completed timely by the worker, DHHS did not meet the designated performance standard of 85 percent for this commitment. In future monitoring periods, detail data will be used to assess performance, and compliance will be determined through the percent of CPS investigations that were both completed by the worker and approved by the supervisor timely.

CPS Investigations and Screening (6.22)

Under the terms of the ISEP, DHHS is required to investigate all allegations of abuse or neglect relating to any child in the foster care custody of DHHS and to ensure that allegations of maltreatment in care are not inappropriately screened out, meaning they are not referred for investigation. In order to report on this provision, DHHS agreed to conduct a QAP review, using a set of questions established by DHHS and the monitors on a statistically valid sample, stratified geographically.

This QAP focused on reports received by DHHS Centralized Intake regarding children and youth in the plaintiff class, that were screened out through rejection or transfer to another entity.[14] For ISEP 10, a sample of 371 screened-out referrals was drawn from a total of 7,437 screened-out referrals. The DCQI unit determined that Centralized Intake made appropriate screening decisions for 368 (99.1 percent) of the referrals. DCQI determined there were three referrals rejected or transferred by Centralized Intake that should have been assigned for investigation.

The monitoring team reviewed and analyzed available records for 50 of the sample cases assessed by DHHS and did not confirm DHHS' reported performance. Of these 50 screened-out

[13] Investigations with approved extensions are included in this data. However, DHHS was unable to report on the reasons why supervisors approved the extensions and whether they fell under one of the three reasons established in the ISEP.

[14] For ISEP 10, DHHS included in the sample all complaints received regarding plaintiff class children that were screened out for investigation during the period, including complaints in which abuse or neglect was alleged to have occurred prior to the child entering DHHS' custody. This sampling methodology will be reviewed by the monitors with DHHS and is subject to change in future reporting periods.

referrals, the monitoring team determined that DHHS made appropriate screening decisions in 35 instances (70 percent). The monitors believe 11 referrals should have been assigned for investigation (22 percent) but were not, and that additional information was needed to make an appropriate screening decision for four referrals (8 percent).

In its QAP, DCQI initially determined all 50 of the referrals had been appropriately screened out for investigation. Following discussions with the monitoring team, DHHS agreed that one additional referral should have been referred and would be assigned for investigation[15]. The monitoring team concluded several other referrals should have been assigned for investigation, though DHHS does not agree. These referrals include allegations that a foster parent kicked a nine-year-old foster child in the scrotum; allegations of sexual abuse of a foster child prior to entry into care; allegations of sexual assault of a foster child in residential care; allegations that a foster parent "whipped" a child; and allegations that caretakers frequently smoked marijuana in front of foster children. DHHS advised that another referral regarding residents in a CCI was transferred to DCWL for investigation; however, the allegations were not investigated by DCWL until 7 months after the referral, and none of the residents involved in the complaint were interviewed as they no longer resided at the facility.

The monitors' review of screening documentation and discussions with DHHS suggest that DHHS at times does not accept an allegation of physical child abuse for investigation unless the allegation affirmatively includes a specific reference to an observable, physical injury, such as brain damage or a bruise, or internal injuries. The monitors identified referrals that suggest unless a physical injury is specifically alleged, DHHS will not investigate the referral for child abuse and neglect, even to assess whether such an injury resulted and even if the action hurt the child. For example, in one of the screened-out cases reviewed by the monitors, a credible professional source alleged a foster parent "kicked [the child] in the balls," but DHHS maintains the referral was properly not referred for investigation because the referent did not know of injuries to the child. This very act – kicking a foster child in the scrotum - on its face meets the definition of assault under the Michigan penal code, but according to DHHS does not rise to the level of warranting an investigation of child abuse and neglect. DHHS coded the matter, which was not the first alleged against this foster parent, as "a disciplinary issue that would more appropriately be addressed by licensing." That initial screening determination was upheld by DCQI as part of its QAP and again by DHHS leadership in subsequent discussions with the monitoring team. The monitors disagree respectfully and strongly.

[15] Although DHHS and the monitors agreed that this referral should be investigated, the monitors subsequently learned that the referral was not investigated for abuse and neglect, even after the monitors and DHHS reached agreement on the proper disposition.

DHHS cited to Michigan's Child Protection Law and its own policies in support of its position. In the first instance, Michigan's Child Protection Law does not require the allegation of an observable physical injury as a requirement for an investigation of child abuse. ACT. No. 238, Section 722.622 (e) defines Child Abuse to mean:

> …harm or threatened harm to a child's health or welfare that occurs through non-accidental physical or mental injury, sexual abuse, sexual exploitation, or maltreatment, by a parent, a legal guardian, or any other person responsible for the child's health or welfare or by a teacher, a teacher's aide, or a member of the clergy.

The Merriam Webster Dictionary defines injury as "an act that damages or hurts." Kicking a foster child in the scrotum, for example, is almost certain to cause the child to hurt, and warrants investigation regardless of whether the referent knows for certain that the child sustained a physical injury. Similarly, "whipping" a foster child is bound to hurt the child, and warrants an abuse investigation.

DHHS also could have referred several of the screened-out referrals, including the referral discussed above, for a child maltreatment investigation. DHHS PSM 711-5, dated May 1, 2016, defines child maltreatment as "[t]he treatment of a child that involves cruelty or suffering that a reasonable person would recognize as excessive." The policy offers several possible examples of maltreatment including "a parent who utilizes locking the child in a closet as a means of punishment, a parent who ties their child to a stationary object as a means to control or punish their child, and a parent who forces their child to eat dog food out of a dog bowl during dinner as a method of punishment and/or humiliation." Kicking a foster child in the scrotum certainly involves cruelty that a reasonable person would recognize as excessive, and warrants, at least, further investigation by child protection services.

The monitoring team also reviewed a sample of referrals to Centralized Intake from DCWL involving the treatment of children in CCIs. A number of these referrals had been screened out by Centralized Intake because DHHS concluded the allegations did not affirmatively list a physical injury to the child. In one instance, a CCI worker was recorded on video pushing a 12-year-old child three times, causing the child to fall to the ground. DHHS declined to launch a child abuse investigation because the referent did not allege that the child was physically injured in the fall. In another instance, a CCI supervisor witnessed a staff member push a child to the ground, causing the child to land on his ribs. Despite this and the child having a prior rib injury in the same area, DHHS declined to launch a child abuse investigation because the referent did not allege that the child was physically injured. In another case, it was alleged that CCI staff punched a child during a restraint. DHHS declined to launch a child abuse investigation because the agency concluded the referent did not allege that the child had been physically injured. However, the DCWL investigator noted the child's lip was bleeding after the restraint.

No one from DHHS ever spoke to the child to try to determine what happened according to all of the available documentary evidence. In another example, a video showed a CCI staff person swinging a book at a 14-year-old boy's head and neck area, then grabbing the boy in the neck/shoulder area and pushing him into his room. The video shows the boy lying face down on the floor with the staff person crouching over him. At one point it appears the staff person is pulling the boy's upper body backwards and toward his chest. The boy stated that the staff person held his neck with both hands and later switched to his arm across the front of his neck while pulling his head away from his body. DCWL issued three violations for staff qualifications, discipline and improper restraint. DHHS declined to launch a child abuse investigation apparently because the referral did not specifically allege that the child had been physically injured.

For the four referrals for which the monitoring team felt additional information was needed, the allegations were vague and raised important, unanswered questions. With additional screening, an informed decision could have been made on whether to assign, reject or transfer the case. DHHS policy requires that "When information received from the reporting person is not sufficient to reach a decision regarding whether or not to assign the complaint for field investigation and to assign a priority code response; CPS must conduct a preliminary investigation." The policy further states that one of the activities should include making contact with any collateral contacts who have direct knowledge relevant to the issue in the complaint in order to assess the child's safety.[16] There was no documentation in these four cases that this occurred. The monitoring team did not conclude DHHS was in compliance with this commitment in light of these findings.

Health and Mental Health

Healthcare Quality Assurance Process Review (6.45, 6.46, 6.48, 6.49, 6.50)

The ISEP contains several areas that are specific to children's health needs, some of which the parties agreed would be measured through a QAP. These commitments include requiring DHHS to:

- Ensure children receive all required immunizations according to the guidelines set forth by the American Academy of Pediatrics (6.45 and 6.46)
- Maintain an up-to-date medical file for each child in care containing the information required by DHHS policy (6.48)

[16] For full DHHS policy, see Appendix C. Michigan DHHS Policy PSM 712-5, CPS Intake – Overview.

- At the time the child is placed or replaced and quarterly thereafter, provide the foster care provider with the child's medical passport (6.49)
- Ensure the case plans contain the information required by DHHS Policy FOM-801 (6.50)

The monitoring team and DHHS agreed that these provisions should be evaluated together and reached agreement on a QAP tool and training for the review. The population for this QAP was comprised of two groups of children. The first group relates to section 6.45 and consists of all children who entered care during the first three months of ISEP 10 and were in care for at least 90 days. The second group pertains to section 6.46 and consists of all children who had been in care more than 90 days as of March 31, 2016. The sample for provisions 6.48, 6.49 and 6.50 consisted of both groups, including all of the children reviewed for 6.45 and 6.46. The sample size was based on a five percent margin of error and a 95 percent confidence level. The designated performance standard for all commitments is 95 percent, which DHHS did not meet.

The ISEP 10 results of the Department's QAP of the five cited commitments are charted below:

Table 5. DHHS ISEP 10 Performance on Health Requirements 6.45, 6.46, 6.48, 6.49 & 6.50

ISEP Commitment	Total Population	Sample Size	Cases Compliant	Cases Noncompliant	Performance Percentage
Immunizations/in care < 3 mos. (6.45)	1,818	310	263	74	84.8%
Immunizations/in care > 3 mos. (6.46)	10,612	412	351	61	85.2%
Up-to-date medical file (6.48)	12,430	722	382	340	52.9%
Medical passports (6.49)	12,430	485	292	193	60.2%[17]
Case plan information (6.50)	12,430	722	364	358	50.4%

The monitoring team conducted a review regarding provisions 6.45 and 6.46. Findings from the review were consistent with the Department's QAP results for these two commitments.

[17] DHHS' performance for this commitment represents the percent of foster care providers who received the child's medical passport at the time of placement or replacement. The ISEP also requires that medical passports be updated on a quarterly basis; however, the Department indicated that the requirement to provide a quarterly medical passport to caregivers necessitated new policy and staff training and was not in full effect during ISEP 10. DHHS will report on this portion of the commitment in ISEP 11.

Medical and Mental Health Examinations for Children (6.43)[18]

DHHS committed in the ISEP that at least 85 percent of children shall have an initial medical and mental health examination within 30 days of the child's entry into foster care. During ISEP 10, the Department completed 1,284 of 1,696 (76 percent) required initial medical and mental health exams within 30 days of a child's entry into care. DHHS committed in the ISEP at least 95 percent of children shall have an initial medical and mental health examination within 45 days of the child's entry into foster care. The Department completed 1,430 of 1,682 (85 percent) required initial medical and mental health exams within 45 days of a child's entry into care. The Department's performance did not meet the designated performance standards set forth in the ISEP for either provision.

Dental Care for Children (6.44)[19]

DHHS committed in the ISEP that at least 90 percent of children shall have an initial dental examination within 90 days of the child's entry into care unless the child has had an exam within six months prior to placement or the child is less than four years of age. During ISEP 10, the Department completed 650 of 945 (69 percent) initial dental exams within the required timeframe, not meeting the standard.

Ongoing Healthcare for Children (6.47)[20]

DHHS committed in the ISEP that following an initial medical, dental or mental health examination, at least 95 percent of children shall receive periodic and ongoing medical, dental, and mental health care examinations and screenings, according to the guidelines set forth by the American Academy of Pediatrics. Performance for this commitment was calculated for each medical type: medical well child visits for children age three and younger, annual physicals for children older than three, and annual dental exams. During ISEP 10, DHHS completed 1,439 of 1,830 (79 percent) medical well child visits timely;[21] 667 of 881 (76 percent) annual physicals

[18] The data submitted for provisions 6.43, 6.44 and 6.47 exclude children who are living with their parents in trial home reunification status. DHHS reported that the Department has no legal authority, without filing a new court petition, to compel a medical or dental visit or to compel a parent to provide information to DHHS regarding follow-up medical or dental care for children living at home with their parents. This reporting methodology will be reviewed by the monitors and is subject to change in future reporting periods.

[19] See footnote 18

[20] See footnote 18

[21] The data submitted by DHHS for medical well child visits counted appointments as timely when these appointments occurred beyond the recommended timeframe as outlined in the AAP guidelines. This methodology will be reviewed by the monitors and is subject to change in future reporting periods.

timely; and 788 of 1,185 (66 percent) annual dental exams timely, failing to meet the designated performance standard.

Access to Health Insurance (6.51, 6.52)

The ISEP requires DHHS to ensure that at least 95 percent of children have access to medical coverage within 30 days of entry into foster care by providing the placement provider with a Medicaid card or an alternative verification of the child's Medicaid status and Medicaid number as soon as it is available (6.51). DHHS provided data from MiSACWIS regarding this provision during ISEP 10. The Department reports that placement providers received a Medicaid card or an alternative verification of the child's Medicaid status and number within 30 days of entry into foster care for 2,984[22] of 3,509 children (85 percent), falling short of the standard.

The ISEP also requires DHHS to ensure that 95 percent of children have access to medical coverage within 24 hours or the next business day following subsequent placement by giving the placement provider a Medicaid card or an alternative verification of the child's Medicaid status and Medicaid number as soon as it is available (6.52). The monitoring team was unable to verify data provided by DHHS for this commitment during ISEP 10. Data provided by DHHS included 979 entries where providers received the medical coverage card before the child was placed and 1,886 entries coded as non-applicable for whether the medical coverage card was provided. The monitors expect to receive data and information from DHHS to support an evaluation of DHHS' performance on this commitment beginning in ISEP 11.

Health Liaison Officers (5.13)

DHHS is to maintain at least 34 Health Liaison Officers, as per the ISEP. At the end of ISEP 10, there were 29 Health Liaison Officers statewide and three more had been hired who started in their positions in July 2016. During the period, one Health Liaison Officers transferred to a different county. DHHS, therefore, did not meet the designated performance standard for this commitment.

[22] This number includes 59 children whose caregivers reportedly received the medical card before the child was placed in their home. DHHS stated circumstances where a provider could be shown as receiving a medical card before placement include: date improperly entered in SACWIS; card given prior to placement at family team meeting or home visit; and Young Adult Voluntary Foster Care or Independent Living youth who hold their own medical card.

Psychotropic Medications (6.53)

The ISEP requires DHHS to ensure that prior to initiating each prescription for psychotropic medication for a child in care, the child must have a mental health assessment with a current DSM-based psychiatric diagnosis of the mental health disorder. The Psychotropic Medication Oversight Unit conducted a review of this commitment. To identify the group of children in care prescribed psychotropic medications, the unit compared a list of children in foster care during the period to a list of Medicaid pharmacy claims for psychotropic medication prescriptions filled within the reporting period.

DHHS identified 3,148 children in foster care during ISEP 10 with a Medicaid paid psychotropic medication claim during the reporting period. Four children were then excluded from the population as they were prescribed the medication prior to entry into care. Of the remaining 3,144 children, 2,986 had a claim with a mental health diagnosis reported prior to the earliest prescription fill in ISEP 10, or had an informed consent logged in the database that was dated prior to the prescription.

The remaining 158 children's cases were assigned to the DHHS psychotropic medication oversight team for an in depth review to determine if they met the requirements of the commitment. The review process consisted of a manual review of additional medical claims, MiSACWIS documents, informed consent documents and case notes. The team located a DSM-based psychiatric diagnosis of the mental health disorder for 91 of the youth and 64 children were excluded as they were prescribed the psychotropic medication to treat a medical condition. Overall, DHHS reported that 3,077 of the 3,080 children (99.9 percent) met the ISEP requirements, exceeding the designated performance standard of 97 percent. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Treatment Foster Homes (6.11)

DHHS committed to have, at any given time, at least 200 treatment foster home beds for youth in foster care. According to information provided to the monitoring team, DHHS has treatment foster home beds through contracts with private agencies to provide placement and services for children who are deemed eligible for a Serious Emotional Disturbance Waiver (SEDW). During ISEP 10, DHHS had 207 treatment foster home beds available for placement. Of these, 187 were licensed and 153 of these licensed beds were utilized by youth receiving SEDW services. Additionally, 20 unlicensed foster home beds were utilized by youth receiving SEDW services.

As outlined by DHHS, services provided to youth receiving SEDW services include but are not limited to wraparound services, intensive home-based therapy, speech therapy, substance abuse treatment, speech/hearing assessment and treatment, occupational therapy, treatment

for health problems, employment services, group therapy, parent to parent support, transportation, community living support, community based activities, education, psychiatric and other services. During ISEP 10, DHHS met its commitment to have at least 200 treatment foster home beds. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

Education

Education, Enrollment and Attendance (6.37)

The ISEP requires that DHHS take reasonable steps to ensure that school-aged foster children are registered and attending school within five days of initial placement or any placement change, including while placed in CCIs or emergency placements. In order to measure the Department's performance in this area, DHHS conducted a QAP utilizing a tool and training developed in coordination with the monitoring team.

The population under review included all children who were six years of age as of December 1, 2015 and had an initial or replacement during the year. The DCQI utilized a statistically significant random sample, stratified by county. The sample size selected for this review was based on a five percent margin of error with a 95 percent confidence level. The total population was 2,061 children and the sample size was 367 children.

As a result of the QAP, the DHHS CQI team found the Department to be in compliance with this provision for 90.8 percent of the cases. Of the 404 cases reviewed, 367 cases were compliant and 37 cases were non-compliant. The monitoring team conducted a review of 25 randomly selected cases stratified by county and CQI reviewer. The monitoring team's review resulted in findings of performance similar to the DHHS CQI team. DHHS was therefore compliant with this commitment during ISEP 10. *Per the ISEP, compliance during this period makes the commitment eligible to move to "To Be Maintained".*

DHHS performance with respect to commitments regarding educational appropriateness (6.36) and continuity (6.38) was measured pursuant to the Quality Service Review and is detailed on page 29 of this report.

Youth Transitioning to Adulthood

Extending Eligibility and Services

YAVFC (5.2)

The ISEP requires DHHS to continue to implement policies and provide services to support youth transitioning to adulthood, including ensuring youth have been informed of services available through the Young Adult Voluntary Foster Care (YAVFC) program, as measured through a QAP. The monitoring team and the DHHS CQI unit met and mutually developed a tool and training to conduct this review.

The population for this review was comprised of all youth in foster care during the reporting period, age 16 through 20. DHHS utilized a statistically valid, random sample, stratified by county. The sample size selected was based on a five percent margin of error and a 95 percent confidence level.

For ISEP 10, the total population consisted of 2,340 youth, with a sample size of 331. DHHS' CQI team found that 158 of 331 youth were informed of the YAVFC program, representing less than half of the cases under review, or 47.7 percent. In the remaining 173 cases there was no documentation in the youth's file that they were informed of services available through the YAVFC program. DHHS did not meet the designated performance standard of 90 percent for this commitment. The monitoring team reviewed a sample of cases assessed by DCQI and confirmed that DHHS did not meet the designated performance standard for this commitment.

Independent Living Services (5.3)

The ISEP also requires DHHS to support youth transitioning to adulthood by ensuring they have access to independent living services through age 20. This requirement is measured through a QAP. The CQI unit and the monitors established a tool and training for staff who were conducting the reviews.

The population for the QAP was comprised of all youth in foster care, age 16 through 20, who had been in care 30 days or longer during the reporting period. A statistically valid random sample that was stratified by county was utilized. The sample size selected for the review was based on a five percent margin of error and a 95 percent confidence level. For ISEP 10, the population consisted of 2,340 youth, with a sample size of 331. DHHS found that 315 of the cases were non-compliant for ensuring youth had access to independent living services and only 16 cases were compliant, for a performance standard of 4.8 percent. The Department did not meet the designated performance standard of 90 percent. The monitoring team reviewed a

sample of cases assessed by DCQI and confirmed that DHHS did not meet the designated performance standard for this commitment.

APPLA Goals (5.7)

DHHS committed to ensure that youth age 16 and older in foster care with a permanency goal of Another Planned Living Arrangement (APPLA), Another Planned Living Arrangement – Emancipation, or adoption without an identified family have access to the range of supportive services necessary to support their preparation for and successful transition to adulthood. The parties agreed that this provision would be measured through a QAP.

The Department and the monitoring team agreed upon a tool for CQI staff to use and training for the staff conducting the review. The population for this review was comprised of youth 16 and older with a goal of APPLA or adoption and no identified family at the end of the period. DCQI utilized a statistically valid random sample, stratified by county. The sample size selected for the review was based on a five percent margin of error and 95 percent confidence level. For ISEP 10, the total population was 963 youth and the sample size was 275 youth. Twenty-four cases were found to be compliant and 251 cases were non-compliant, for a performance standard of 8.7 percent. The Department did not meet the designated performance standard of 90 percent. The monitoring team reviewed a sample of cases assessed by DCQI and confirmed that DHHS did not meet the designated performance standard for this commitment.

Immediate Actions for Youth Transitioning to Adulthood

Family Team Meetings (5.6)

DHHS pledged to hold a Family Team Meeting (FTM) for each youth age 16 and older occurring 90 days before planned discharge from care or within 30 days after an unexpected discharge. The meeting functions as an opportunity to inform youth leaving the child welfare system about resources available in their community, such as public benefits, housing, education, employment, transportation, financial management and health. The parties agreed that this provision would be measured through a QAP.

The Department and the monitoring team agreed upon a set of questions to be utilized and training to guide staff conducting the review. The population under review was comprised of all youth 16 and older who exited care during the ISEP reporting period. CQI utilized a statistically valid random sample, stratified by county. The sample size selected for this review was based on a five percent margin of error and a 95 percent confidence level. For ISEP 10, the population consisted of 582 children, with a sample size of 236 children. Of the cases reviewed, DHHS found that 209 were non-compliant with the ISEP commitment and only 27 cases were compliant, for a performance standard of 11.4 percent. DHHS therefore did not meet the

designated performance standard of 90 percent for this commitment. The monitoring team assessed a sample of cases reviewed by DCQI and confirmed that DHHS did not meet the designated performance standard for this commitment.

Michigan Youth Opportunities Initiative and Individual Development Accounts (5.4, 5.5)

DHHS committed to continue to implement policies and provide services to support youth transitioning to adulthood, including maintaining the Michigan Youth Opportunities Initiative (MYOI) programming at levels consistent with those in Michigan in January 2016. MYOI provides support and services to youth aging out of foster care. DHHS also agreed to maintain established MYOI coordinators.

During ISEP 10, MYOI was active in 64 counties, with 31 MYOI Coordinators statewide. During the reporting period, there were three additional staff who administered MYOI while also completing other direct services unrelated to MYOI.

Supports to youth included independent living skills trainings and youth board trainings. On average, these occurred monthly in each MYOI site. More frequent meeting and training opportunities occurred in some of the larger MYOI sites. DHHS reported that 208 youth board meetings and 315 independent living skills trainings were held during the reporting period. In addition, a focus on community partner development occurred to improve community supports for MYOI youth and youth in foster care. DHHS reported that 113 community partnership meetings were held during the reporting period.

Supportive services to youth included transportation, accessing Chafee funding, banking, credit recovery, educational support, emotional support, housing, clothing access, internet access, criminal justice assistance, emergency funding, family team meetings, parenting support and financial management. DHHS reported that 63 financial literacy trainings, 53 volunteer activities, and 94 fundraising events were held during the reporting period.

There were 862 actively enrolled youth at the end of the period, including 92 new enrollments. Since program implementation, 2,592 youth have been enrolled in MYOI.

At the end of ISEP 10, there were 1,083 Individual Development Accounts open and active. DHHS achieved compliance with this commitment as a result of these activities.

Appendix A. Age Range of Children in Care on June 30, 2016 by County

County Name	Age Group of Children in Care on June 30, 2016								Total
	Ages 0-6		Ages 7-11		Ages 12-17		Ages 18+		
	Children	%	Children	%	Children	%	Children	%	Children
MISSING	0	0%	0	0%	1	50%	1	50%	2
ALCONA	15	54%	3	11%	8	29%	2	7%	28
ALGER	6	55%	1	9%	3	27%	1	9%	11
ALLEGAN	64	44%	41	28%	37	25%	5	3%	147
ALPENA	32	51%	14	22%	16	25%	1	2%	63
ANTRIM	14	61%	3	13%	3	13%	3	13%	23
ARENAC	17	45%	9	24%	9	24%	3	8%	38
BARAGA	10	83%	0	0%	0	0%	2	17%	12
BARRY	33	62%	11	21%	8	15%	1	2%	53
BAY	66	50%	19	15%	43	33%	3	2%	131
BENZIE	6	43%	0	0%	6	43%	2	14%	14
BERRIEN	175	47%	87	23%	92	24%	22	6%	376
BRANCH	49	56%	18	20%	17	19%	4	5%	88
CALHOUN	127	51%	55	22%	60	24%	8	3%	250
CASS	71	43%	48	29%	44	26%	4	2%	167
CENTRAL OFFICE	53	62%	6	7%	7	8%	20	23%	86
CHARLEVOIX	7	30%	6	26%	7	30%	3	13%	23
CHEBOYGAN	19	51%	7	19%	10	27%	1	3%	37
CHIPPEWA	21	40%	18	35%	12	23%	1	2%	52
CLARE	34	41%	22	27%	25	30%	2	2%	83
CLINTON	22	58%	6	16%	10	26%	0	0%	38
CRAWFORD	12	29%	10	24%	18	43%	2	5%	42
DELTA	31	69%	7	16%	6	13%	1	2%	45
DICKINSON	23	61%	5	13%	7	18%	3	8%	38
EATON	48	48%	18	18%	26	26%	7	7%	99
EMMET	8	40%	6	30%	5	25%	1	5%	20
GENESEE	237	47%	100	20%	121	24%	50	10%	508
GLADWIN	16	48%	5	15%	11	33%	1	3%	33
GOGEBIC	28	58%	8	17%	7	15%	5	10%	48
GRAND TRAVERSE	40	55%	17	23%	15	21%	1	1%	73
GRATIOT	21	58%	7	19%	8	22%	0	0%	36
HILLSDALE	61	55%	25	23%	24	22%	0	0%	110
HOUGHTON	3	19%	4	25%	9	56%	0	0%	16
HURON	27	47%	20	34%	10	17%	1	2%	58
INGHAM	304	50%	131	22%	126	21%	43	7%	604
IONIA	20	43%	11	24%	10	22%	5	11%	46
IOSCO	23	45%	11	22%	17	33%	0	0%	51
IRON	7	50%	3	21%	4	29%	0	0%	14
ISABELLA	51	59%	23	26%	12	14%	1	1%	87
JACKSON	149	51%	51	17%	78	27%	16	5%	294
KALAMAZOO	298	53%	113	20%	125	22%	31	5%	567
KALKASKA	15	58%	2	8%	5	19%	4	15%	26
KENT	372	48%	185	24%	165	21%	53	7%	775
LAKE	13	39%	6	18%	11	33%	3	9%	33
LAPEER	35	54%	12	18%	13	20%	5	8%	65

County Name	Age Group of Children in Care on June 30, 2016								Total
	Ages 0-6		Ages 7-11		Ages 12-17		Ages 18+		
	Children	%	Children	%	Children	%	Children	%	Children
LEELANAU	4	33%	5	42%	3	25%	0	0%	12
LENAWEE	59	64%	13	14%	18	20%	2	2%	92
LIVINGSTON	56	42%	36	27%	34	26%	7	5%	133
LUCE	15	54%	7	25%	4	14%	2	7%	28
MACKINAC	6	38%	3	19%	6	38%	1	6%	16
MACOMB	238	49%	87	18%	112	23%	48	10%	485
MANISTEE	17	50%	9	26%	6	18%	2	6%	34
MARQUETTE	19	54%	7	20%	7	20%	2	6%	35
MASON	33	52%	14	22%	14	22%	2	3%	63
MECOSTA	12	38%	2	6%	16	50%	2	6%	32
MENOMINEE	13	65%	6	30%	0	0%	1	5%	20
MIDLAND	39	48%	15	18%	26	32%	2	2%	82
MISSAUKEE	2	20%	2	20%	4	40%	2	20%	10
MONROE	109	53%	51	25%	39	19%	5	2%	204
MONTCALM	29	38%	11	14%	32	42%	4	5%	76
MONTMORENCY	10	48%	6	29%	4	19%	1	5%	21
MUSKEGON	188	52%	72	20%	73	20%	29	8%	362
NEWAYGO	35	34%	34	33%	30	29%	4	4%	103
OAKLAND	371	46%	178	22%	197	24%	61	8%	807
OCEANA	7	30%	13	57%	3	13%	0	0%	23
OGEMAW	14	31%	10	22%	19	42%	2	4%	45
ONTONAGON	5	100%	0	0%	0	0%	0	0%	5
OSCEOLA	7	58%	3	25%	1	8%	1	8%	12
OSCODA	10	67%	2	13%	2	13%	1	7%	15
OTSEGO	21	51%	10	24%	8	20%	2	5%	41
OTTAWA	84	49%	36	21%	43	25%	7	4%	170
PRESQUE ISLE	14	82%	3	18%	0	0%	0	0%	17
ROSCOMMON	11	35%	8	26%	9	29%	3	10%	31
SAGINAW	75	51%	28	19%	37	25%	8	5%	148
SANILAC	32	58%	10	18%	8	15%	5	9%	55
SCHOOLCRAFT	9	64%	1	7%	4	29%	0	0%	14
SHIAWASSEE	36	47%	18	24%	19	25%	3	4%	76
ST. CLAIR	142	53%	62	23%	56	21%	10	4%	270
ST. JOSEPH	109	55%	50	25%	34	17%	7	4%	200
TUSCOLA	44	46%	19	20%	26	27%	6	6%	95
VAN BUREN	88	51%	41	24%	36	21%	6	4%	171
WASHTENAW	84	45%	37	20%	49	26%	18	10%	188
WAYNE	1255	49%	495	19%	557	22%	261	10%	2568
WEXFORD	29	62%	8	17%	9	19%	1	2%	47
Total	**6014**	**49%**	**2566**	**21%**	**2796**	**23%**	**840**	**7%**	**12216**

Note: Some row percentage totals may not add to 100 percent due to rounding.

Appendix B. Length of Stay of Children in Care on June 30, 2016 by County

County Name	Length of Stay of Children in Foster Care on June 30, 2016										Total
	Less than 1 year		1-2 years		2-3 years		3-6 years		6+ years		
	Children	%	Children	%	Children	%	Children	%	Children	%	Children
MISSING	1	50%	1	50%	0	0%	0	0%	0	0%	2
ALCONA	6	21%	11	39%	2	7%	7	25%	2	7%	28
ALGER	3	27%	4	36%	0	0%	3	27%	1	9%	11
ALLEGAN	74	50%	51	35%	16	11%	3	2%	3	2%	147
ALPENA	37	59%	19	30%	4	6%	2	3%	1	2%	63
ANTRIM	10	43%	6	26%	5	22%	2	9%	0	0%	23
ARENAC	24	63%	11	29%	1	3%	2	5%	0	0%	38
BARAGA	4	33%	6	50%	0	0%	2	17%	0	0%	12
BARRY	33	62%	12	23%	5	9%	2	4%	1	2%	53
BAY	68	52%	34	26%	16	12%	12	9%	1	1%	131
BENZIE	6	43%	3	21%	0	0%	5	36%	0	0%	14
BERRIEN	235	63%	83	22%	25	7%	25	7%	8	2%	376
BRANCH	42	48%	30	34%	11	13%	4	5%	1	1%	88
CALHOUN	140	56%	67	27%	33	13%	10	4%	0	0%	250
CASS	93	56%	38	23%	21	13%	15	9%	0	0%	167
CENTRAL OFFICE	33	38%	28	33%	3	3%	18	21%	4	5%	86
CHARLEVOIX	11	48%	2	9%	5	22%	5	22%	0	0%	23
CHEBOYGAN	18	49%	17	46%	0	0%	2	5%	0	0%	37
CHIPPEWA	19	37%	16	31%	11	21%	5	10%	1	2%	52
CLARE	38	46%	31	37%	11	13%	3	4%	0	0%	83
CLINTON	21	55%	14	37%	1	3%	1	3%	1	3%	38
CRAWFORD	15	36%	12	29%	9	21%	3	7%	3	7%	42
DELTA	32	71%	10	22%	2	4%	0	0%	1	2%	45
DICKINSON	23	61%	8	21%	5	13%	1	3%	1	3%	38
EATON	49	49%	25	25%	14	14%	8	8%	3	3%	99
EMMET	5	25%	9	45%	2	10%	3	15%	1	5%	20
GENESEE	277	55%	122	24%	46	9%	32	6%	31	6%	508
GLADWIN	24	73%	3	9%	3	9%	1	3%	2	6%	33
GOGEBIC	33	69%	8	17%	1	2%	5	10%	1	2%	48
GRAND TRAVERSE	45	62%	16	22%	8	11%	0	0%	4	5%	73
GRATIOT	17	47%	11	31%	0	0%	8	22%	0	0%	36
HILLSDALE	66	60%	32	29%	10	9%	2	2%	0	0%	110
HOUGHTON	9	56%	0	0%	4	25%	3	19%	0	0%	16
HURON	30	52%	22	38%	5	9%	0	0%	1	2%	58
INGHAM	319	53%	134	22%	75	12%	62	10%	14	2%	604
IONIA	30	65%	12	26%	1	2%	2	4%	1	2%	46
IOSCO	20	39%	16	31%	8	16%	5	10%	2	4%	51
IRON	14	100%	0	0%	0	0%	0	0%	0	0%	14
ISABELLA	57	66%	17	20%	7	8%	5	6%	1	1%	87
JACKSON	180	61%	55	19%	30	10%	25	9%	4	1%	294
KALAMAZOO	265	47%	183	32%	66	12%	41	7%	12	2%	567
KALKASKA	14	54%	7	27%	4	15%	1	4%	0	0%	26
KENT	371	48%	229	30%	106	14%	56	7%	13	2%	775

County Name	Length of Stay of Children in Foster Care on June 30, 2016										Total
	Less than 1 year		1-2 years		2-3 years		3-6 years		6+ years		
	Children	%	Children	%	Children	%	Children	%	Children	%	Children
LAKE	8	24%	11	33%	8	24%	6	18%	0	0%	33
LAPEER	42	65%	16	25%	2	3%	5	8%	0	0%	65
LEELANAU	6	50%	1	8%	0	0%	3	25%	2	17%	12
LENAWEE	64	70%	14	15%	6	7%	6	7%	2	2%	92
LIVINGSTON	56	42%	54	41%	18	14%	4	3%	1	1%	133
LUCE	4	14%	9	32%	10	36%	4	14%	1	4%	28
MACKINAC	6	38%	1	6%	2	13%	5	31%	2	13%	16
MACOMB	200	41%	131	27%	76	16%	60	12%	18	4%	485
MANISTEE	20	59%	8	24%	0	0%	5	15%	1	3%	34
MARQUETTE	24	69%	4	11%	5	14%	1	3%	1	3%	35
MASON	36	57%	23	37%	1	2%	1	2%	2	3%	63
MECOSTA	12	38%	7	22%	6	19%	6	19%	1	3%	32
MENOMINEE	11	55%	8	40%	0	0%	1	5%	0	0%	20
MIDLAND	37	45%	31	38%	9	11%	4	5%	1	1%	82
MISSAUKEE	3	30%	3	30%	2	20%	2	20%	0	0%	10
MONROE	98	48%	61	30%	27	13%	16	8%	2	1%	204
MONTCALM	35	46%	23	30%	5	7%	10	13%	3	4%	76
MONTMORENCY	13	62%	3	14%	5	24%	0	0%	0	0%	21
MUSKEGON	224	62%	79	22%	34	9%	18	5%	7	2%	362
NEWAYGO	36	35%	25	24%	29	28%	13	13%	0	0%	103
OAKLAND	351	43%	238	29%	114	14%	74	9%	30	4%	807
OCEANA	16	70%	5	22%	2	9%	0	0%	0	0%	23
OGEMAW	20	44%	21	47%	2	4%	0	0%	2	4%	45
ONTONAGON	0	0%	5	100%	0	0%	0	0%	0	0%	5
OSCEOLA	6	50%	1	8%	3	25%	0	0%	2	17%	12
OSCODA	7	47%	8	53%	0	0%	0	0%	0	0%	15
OTSEGO	20	49%	16	39%	3	7%	0	0%	2	5%	41
OTTAWA	104	61%	41	24%	14	8%	9	5%	2	1%	170
PRESQUE ISLE	10	59%	5	29%	2	12%	0	0%	0	0%	17
ROSCOMMON	11	35%	8	26%	2	6%	6	19%	4	13%	31
SAGINAW	88	59%	32	22%	15	10%	11	7%	2	1%	148
SANILAC	24	44%	15	27%	14	25%	2	4%	0	0%	55
SCHOOLCRAFT	5	36%	6	43%	1	7%	2	14%	0	0%	14
SHIAWASSEE	41	54%	20	26%	9	12%	6	8%	0	0%	76
ST. CLAIR	131	49%	76	28%	36	13%	24	9%	3	1%	270
ST. JOSEPH	116	58%	58	29%	12	6%	9	5%	5	3%	200
TUSCOLA	50	53%	25	26%	11	12%	8	8%	1	1%	95
VAN BUREN	116	68%	35	20%	14	8%	3	2%	3	2%	171
WASHTENAW	61	32%	68	36%	26	14%	26	14%	7	4%	188
WAYNE	1037	40%	680	26%	414	16%	274	11%	163	6%	2568
WEXFORD	27	57%	12	26%	6	13%	1	2%	1	2%	47
Total	**5987**	**49%**	**3302**	**27%**	**1521**	**12%**	**1016**	**8%**	**390**	**3%**	**12216**

Note: Some row percentage totals may not add to 100 percent due to rounding.

Appendix C. Michigan DHHS CPS Policy PSM 712-5, CPS Intake - Overview

ELICITING COMPLAINT INFORMATION

The reporting person should be asked to be as specific as possible about the alleged abuse or neglect, indicating what was observed or heard that caused suspicion of abuse or neglect. To assist in determining the appropriateness of a complaint for investigation by CPS and to assess the seriousness of the situation, the following guidelines are suggested when discussing the situation with the reporting person.

- How, specifically, does the reporting person believe the child is at risk of harm (threatened harm) or has been harmed by abuse or neglect?
- What specifically occurred? Did the reporting person see or hear something? Does someone else have first-hand knowledge?
- What are the ages of the children? Are any children under 6 years old? These children are particularly vulnerable and care should be exercised in assessing such complaints.
- Is any child singled out for maltreatment?
- Is this a chronic or isolated instance? If chronic, how often does it occur: daily, weekly, yearly? When did incident occur last?
- Is a child in immediate physical danger?
- What is the reporting person's relationship to the family and household? What is the possible motivation for the complaint?
- Have the relationships between the reporting person and the household been friendly, difficult, strained, etc.?
- Has the reporting person spoken to the responsible person(s) about this matter and the concern expressed? Are, or have there recently been, other agencies involved with the household that might have information about the situation? These should be identified.

REQUIRED CHECKS FOR LICENSING STATUS

Inquiries must be made in an attempt to verify the licensing status of persons associated with the complaint. These inquiries are to be supported by SWSS clearances conducted by Centralized Intake (CI) to determine if a licensed provider is identified as a member of the CPS complaint.

The reporting person must be asked if anyone affiliated with the case is a licensed foster care provider, licensed day care provider or a relative provider. A SWSS Soundex check must be completed for all child(ren) listed on the complaint. Intake staff will document if any of the children in the home are listed within SWSS as foster children.

These clearances must be documented in the complaint source comment section in SWSS.

Allegations

When allegations are entered in SWSS CPS, proofread to ensure that the identity of the reporting person is not revealed. Once a determination is made to assign, transfer, or reject the complaint, the allegations cannot be changed.

When selecting allegations under the Allegations tab in SWSS CPS, select at least one yellow-highlighted abuse/neglect type in the Abuse/Neglect Code tab. Also select any of the unhighlighted factors if the reporting person indicates the presence of those factors in the home (for example, domestic violence, drug residence, drug-exposed infant, etc.).

Death of a Child

Document that the complaint is regarding a child death by checking the Child Fatality box on the Allegations tab and entering the date of death in the Case Member tab of SWSS CPS; see PSM 712-6, CPS Intake-Special Cases, Death Of A Child section.

PRELIMINARY INVESTIGATION

When information received from the reporting person during intake is not sufficient to reach a decision regarding whether or not to assign the complaint for field investigation and to assign a priority

response, CPS must conduct a preliminary investigation. A preliminary investigation must begin immediately upon conclusion of the intake contact. Within 24 hours of receipt of the complaint, a decision must be made to accept and assign for CPS field investigation, to transfer to another unit that has jurisdiction to investigate (for example, the prosecuting attorney and/or law enforcement, American Indian Tribal Unit, another state, Bureau of Child and Adult Licensing, etc.) or to reject the complaint.

Activities which may be part of a preliminary investigation include the following:

A. Complete a **statewide** SWSS CPS Soundex search on all persons listed on the complaint. Determine the history and credibility of former complaints. **Note:** SWSS CPS Soundex searches can be completed on a specific county. To be considered a statewide search, the Soundex search must be completed statewide by selecting "0 Non-spec. County" in SWSS CPS.

B. Complete a central registry inquiry to identify past perpetrators. The central registry clearance must be completed on all persons listed on the complaint who are age 18 or older.

C. Complete a LEIN check on all persons potentially responsible for the child's health and welfare for all sexual abuse, physical abuse, substance abuse (including methamphetamine exposure) and/or domestic violence allegations.

D. Conduct or make contact with any collateral contacts who have direct knowledge relevant to the issues in the complaint in order to assess the child's safety. This can include: a neighbor, pastor, day care provider, school, medical facility, etc.

E. Consult with DHS professional staff (for example, CPS, FIS, foster care, etc.) to clarify relevant issues in the complaint.

Document all of the steps of the preliminary investigation that were completed in the Update/View Preliminary Investigation box in the Ready for Action tab of the Intake module in SWSS CPS.

Contacts at Intake

Contacts made during intake must be entered into SWSS CPS in the Social Work Contacts module.

Note: If any field contacts are made, the complaint must be assigned for field investigation.

MULTIPLE COMPLAINTS

When the current complaint is at least the third CPS complaint on a family **and** the complaint includes a child age 3 or under, CPS must conduct a preliminary investigation covering, at a minimum, steps (A-C) above. Additional steps, including but not limited to steps D and E, should be completed when necessary to assist the department in making appropriate decisions regarding assignment.

Note: When the information received during the current complaint is enough to determine the complaint should be assigned for investigation, a preliminary investigation does not need to be completed. See PSM 713-09, Completion of Investigation, Multiple Complaints section for requirements when these complaints are assigned for field investigation.

If there is already an assigned investigation or an open case, a copy of the rejected complaint must be forwarded to the assigned worker for his/her information and any necessary follow-up regarding the allegations; see PSM 712-8, CPS Intake Completion.