

# State of Michigan Department of Human Services

---

**Special Review of Higher Risk Cases  
Quarterly Report: 10/1/10 - 12/31/10**



## Table of Contents

Preface.....	3
Introduction.....	3
Review Process.....	4
Results and Assessment: Cohort A.....	6
Results: Cohort B.....	7
Quality Assurance Assessment: Cohort B.....	13
Results: Cohort C.....	15
Quality Assurance Assessment: Cohort C.....	18
Results: Cohort D.....	21
Quality Assurance Assessment: Cohort D.....	24
Results: Cohort E.....	26
Quality Assurance Assessment: Cohort E.....	28
Conclusion.....	30
Recommendations.....	31
Follow Up.....	32

## Preface

The Michigan Department of Human Services (DHS) is responsible for administering the state's child welfare programs. The DHS mission includes a commitment to ensure that children and youths served by our public and private providers are, first and foremost, safe, receive high quality services that enhance their well-being, and have permanent and stable families and lives. This mission is executed with help from the Children's Services Administration (CSA), which is responsible for planning, directing, and coordinating statewide child welfare programs.

On July 3, 2008, Governor Granholm, on behalf of Michigan, reached an out-of-court agreement with Children's Rights, Inc. regarding the Dwayne B. v. Granholm, et al. lawsuit. The agreement provides Michigan with a valuable opportunity to reform our existing child welfare system. The agreement builds upon reform efforts already under way and improves safety for children while providing stronger support and oversight for those responsible for them. This agreement is generally referred to as the "consent decree" and is often cited in this report.

## Introduction

The Child Welfare QA unit has been established as an element of the Federal Compliance Division to ensure the provision of services is in accordance with DHS philosophy and federal standards of safety, well-being, and permanency. Part of the Child Welfare QA unit's aim is to foster a continuous quality improvement (CQI) culture throughout DHS by introducing CQI concepts at all levels of the child welfare system. A key role is the training of staff on improvement processes and integrating CQI philosophy into long-term and everyday decision making. The QA unit is working to develop an internal capacity to undertake data collection, verification, and analysis in addition to completing case record reviews for the higher risk cases identified in the consent decree.

In April 2009, the QA unit began to conduct special reviews as specified by the consent decree. The Data Management unit (DMU) provides an initial list of identified cases for the high-risk categories. The QA unit reviews each identified case in the Services Worker Support System (SWSS) to pre-screen for possible data errors, and ensure that the case meets the cohort definition.

The QA unit completed special reviews of higher risk cases as defined by the consent decree for October 1, 2010 through December 31, 2010. As of December 31, 2010, the QA unit has authored four state reports on the special reviews of higher risk cases: Review of Higher Risk Cases: 7/1/09 – 9/30/09,

Maltreatment Cohorts A & B; Special Review of Higher Risk Cases Period Three: 10/1/09 – 3/31/10; Special Review of Higher Risk Cases Quarterly Report: 4/1/10 – 6/30/10; and Special Review of Higher Risk Cases Quarterly Report: 7/1/10 – 9/30/10. Based on the findings noted in these reports, plus additional acquired data, the QA unit is identifying patterns and trends to identify needs for policy and/or practice changes. This report contains a summary of the findings for the special case reviews conducted for the October 1, 2010 through December 31, 2010 review period, as well as some comparisons to the data collected over the past year.

## Review Process

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

The QA unit developed a comprehensive case reading tool to conduct the special reviews. The case review process has evolved and will continue to change as we strive to improve the structure of the tool and refine the steps to obtain required information. The current version is in Microsoft Excel and is designed to structure a review of the file and capture information relevant to each high risk category.

The Data Management unit provides the QA unit with an initial list of cases identified as meeting the requirements of each special review cohort. Prior to conducting a full review, CQI analysts screen each case on the initial list to determine if the case information on SWSS confirms that the case meets the requirements of the cohort. For all cohorts, except Cohorts A and B, if a case was previously reviewed by the QA unit, it will be screened out for future reviews. However, in Cohorts A and B, if a case had been reviewed and a new complaint of child abuse/neglect is received while the youth remains in the home, the CQI analyst will review the case again. The focus of this second review is to determine the quality of the investigation and what, if any, actions or patterns are evident since the initial case review.

Once the CQI analyst screens each child on the list and determines eligibility, the analyst completes a full case review, which includes reading information contained in SWSS-FAJ (Social Work Contacts and Updated Services Plans/Permanent Ward Services Plans), the foster care case file (review and verification of necessary documentation corresponding to the time frame), Children's Protective Services Investigation Reports (DHS-154) as needed, and the licensing file, when appropriate. Case worker interviews are conducted for clarification as necessary.

Upon completion of a case review, the analyst provides feedback to each local field office through exit interviews and county summaries. The analyst discusses recommendations for improvement with the local management team and requests the development of a Quality Improvement Plan (QIP) based on the review findings. The QIP is a tool used to identify, track, and update progress on targeted areas for improvement in each county or district office. It is the responsibility of the analyst and the local office to monitor and assess the county's progress on the QIP to track and verify the improvements.

## **Results and Assessment: Cohort A**

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

As of 10/3/2010, all cases that met the definition of this static cohort had been reviewed. There were no reviews or re-reviews completed for this cohort this quarter. The QA unit is preparing a comprehensive assessment of all cases reviewed in this and all other cohorts, with the intention of presenting this information to the consent decree monitors and, ultimately, requesting the termination of these special reviews.

In all prior reviews for this cohort, QA noted that communication among programs (CPS, foster care, licensing) and documentation of contacts are consistent areas of concern. Failure to recognize this vital communication issue could indirectly affect the safety and well-being of the children in care. Information that might seem insignificant at the time it was received could play an essential role in the safety, well-being, and permanency of that child in the future. This finding has been a noted pattern not only in this cohort, but also in Cohort B, as noted in that section below. QA made recommendations to the counties to review and address this concern on a local level, and has also made recommendations on a state level to evaluate policy and training regarding this issue. The counties and department program offices have identified action steps that are being implemented, and the progress of those improvement plans will be monitored by the QA unit.

## Results: Cohort B

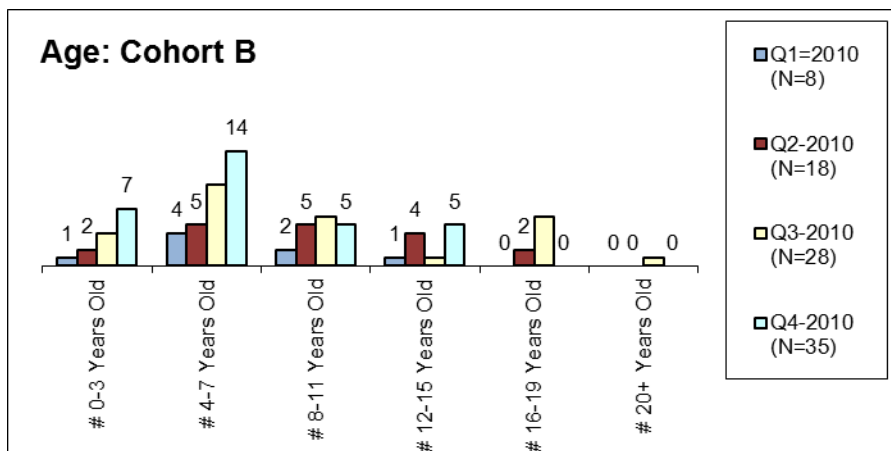
*Definition: Children, not in Cohort A, who have been the subject of three or more reports alleging abuse or neglect in a foster home, the most recent of which reports was filed during or after July 2007, and who remain in the foster home in which maltreatment is alleged to have occurred.*

The Data Management Unit identified 85 cases as meeting the definition of this cohort in the 10/1/2010 data pull.

- Fifty of the 85 cases were screened out as they had either been previously reviewed by the QA unit and there was no change since the last review or it was determined that the case did not meet the requirements of the cohort at the time of review.
- Overall, 35 cases remained. These 35 cases received comprehensive reviews of SWSS and the case records.
- Nine of the 35 cases were previously reviewed by the QA unit; however, because a new complaint of child abuse/neglect was received, the CQI analyst completed another assessment of the most recent complaint. The purpose behind this second review is to evaluate if any new patterns have been detected due to the new allegations.

Fourteen of the 35 cases were under the direct responsibility of DHS and 21 were under the direct responsibility of private child placing agencies.

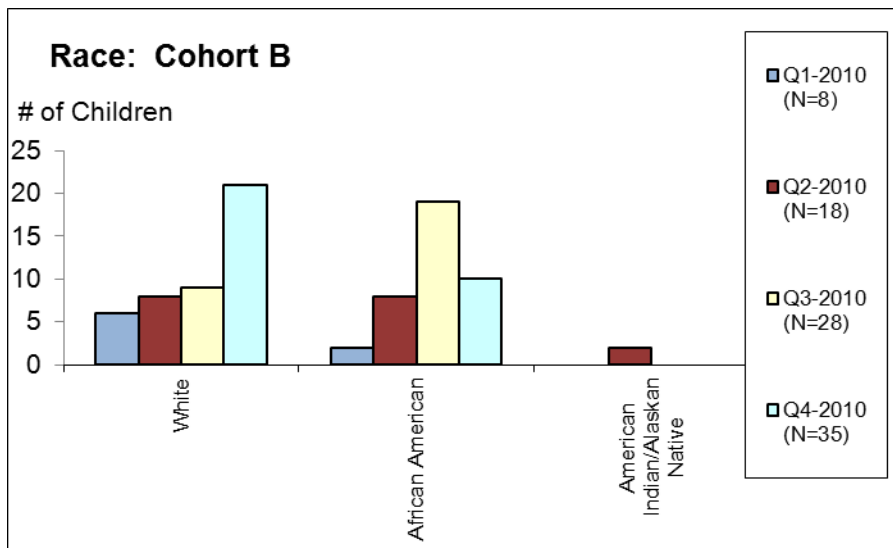
*The following five graphs offer a demographic comparison of the children identified in this cohort for all review periods in 2010.*



The chart above compares the ages of the identified youths for this cohort in each quarter throughout the year of 2010. The QA unit has not identified a significant pattern or trend when comparing the ages. The median age of the children in this cohort is as follows:

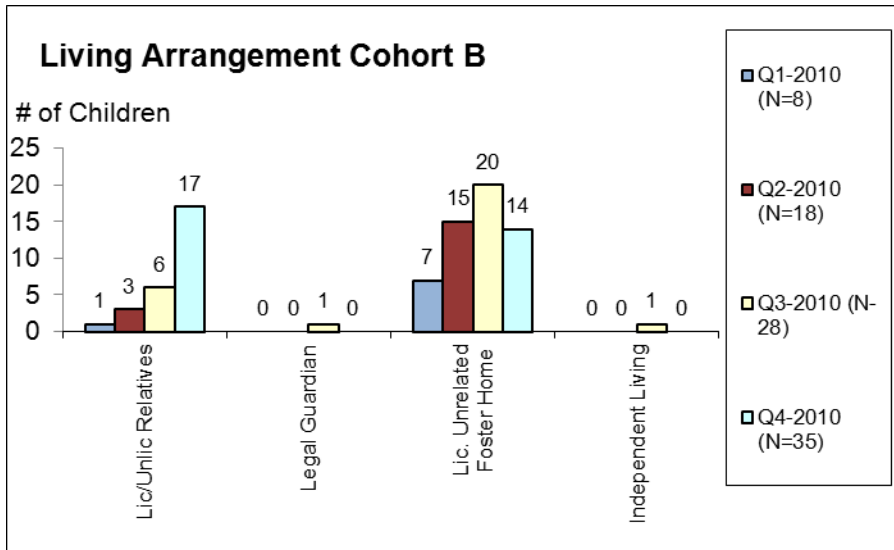
- Quarter Four (October – December 2010) median age: six years
- Quarter Three (July – September 2010) median age: seven years
- Quarter Two (April – June 2010) median age: nine years
- Quarter One (January – March 2010) median age: four years.

The QA unit has not identified any significance in the median age of the children in this cohort.

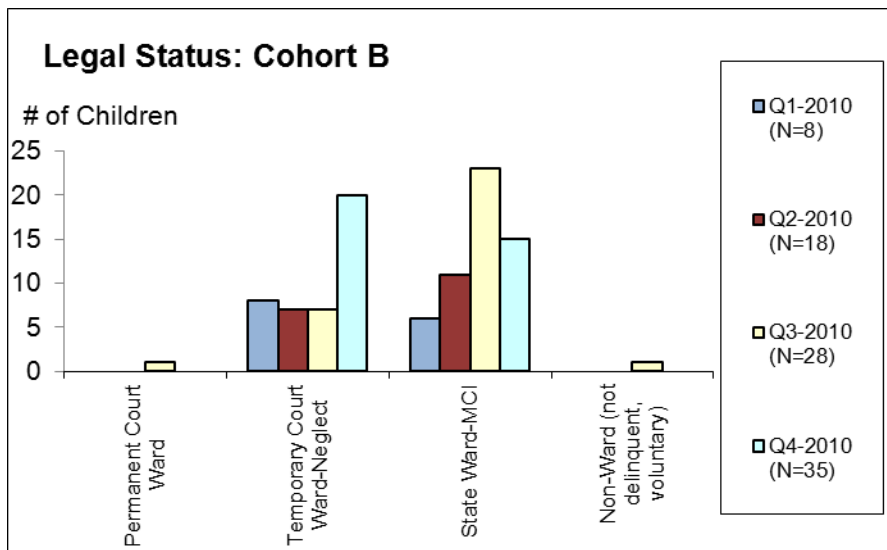


Three races have been represented in this cohort: white, African American, and American Indian/Alaskan native. For this cohort, the ratio of African American children to white children has varied from quarter to quarter. Overall, there has been no clear indication that one race was disproportionately represented in this cohort.

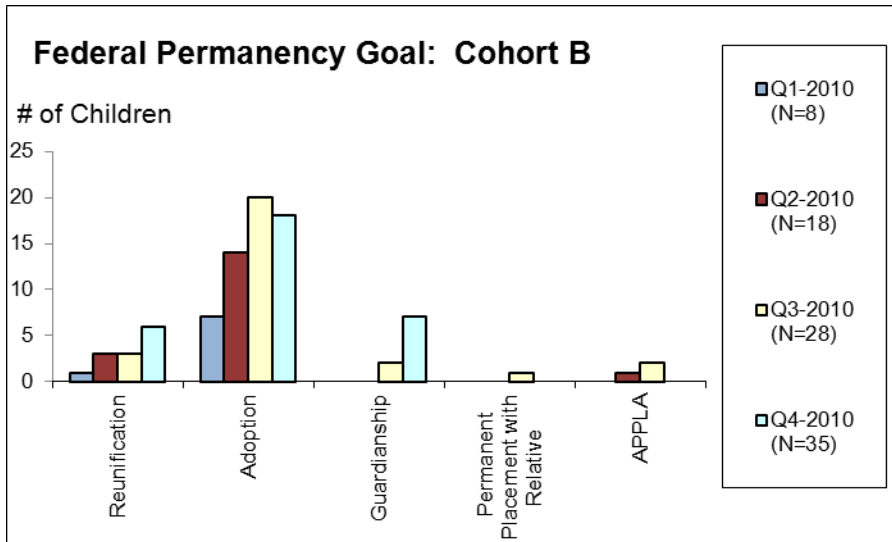




Of all the cases reviewed for Cohort B in 2010, four living arrangements were identified: licensed/unlicensed relatives, licensed unrelated foster homes, legal guardians, and independent living situations. Placement in licensed foster homes and relative homes has consistently remained the prominent living arrangements for children identified for this cohort.



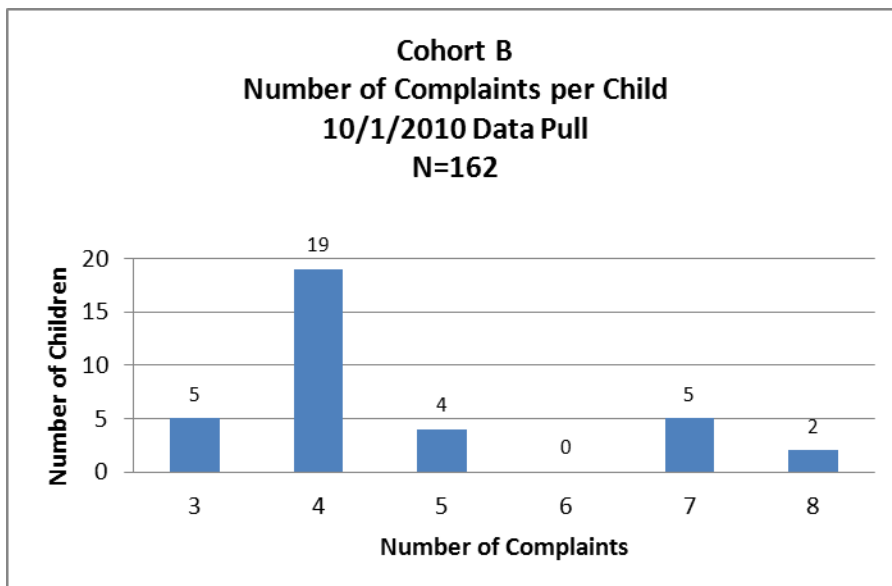
The above graph identifies the legal status of the children identified for this cohort in 2010: permanent court wards, temporary court wards, MCI wards, and non-wards. MCI ward is the most prominent legal status, making up 54 percent of the total identified legal statuses for 2010. Temporary court ward is the second most-identified status, with 35 percent.



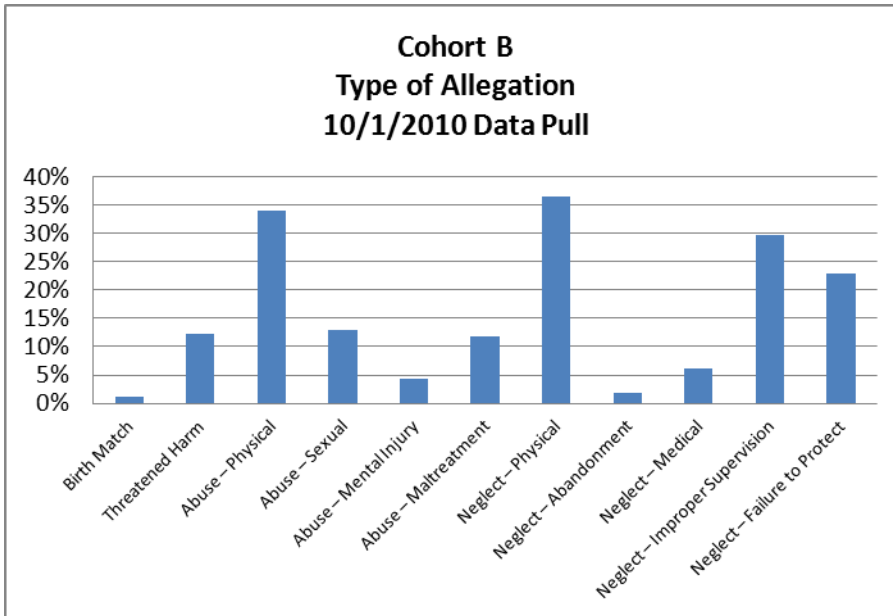
The above graph identifies the federal permanency goals of the children identified for this cohort. Adoption has consistently been the most prominent federal permanency goal.

*The following graphs outline cohort-specific information for the cases reviewed this quarter.*

*The 2010 Quarter Four data pull identified 35 individual foster care cases that required review. However, due to siblings placed in the same foster homes, there were only 20 identified households. The data reported below is per child, not per household.*

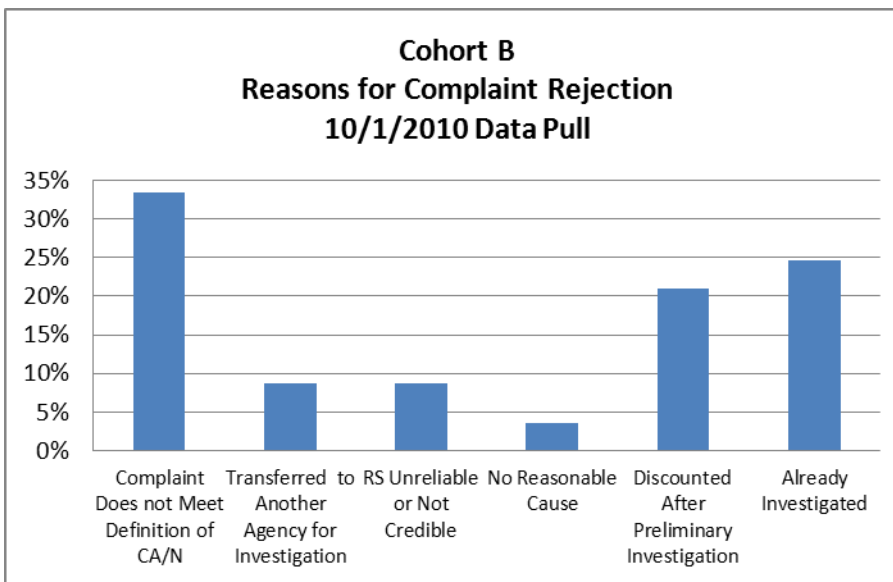


One hundred sixty-two CPS complaints were reviewed for the 35 children in this cohort. The above graph illustrates that the number of complaints ranged from three to eight per child.

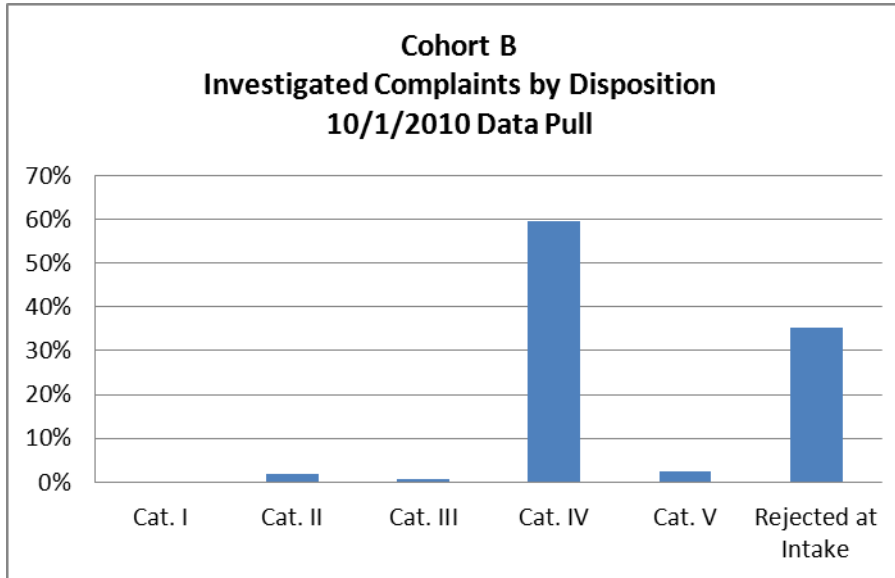


The graph above illustrates the types of allegations contained within the complaints. Within each complaint there was at least one, but sometimes several, different types of allegations of child abuse or neglect.

The alleged perpetrator in 46.3 percent of the complaints was a foster parent, 48.8 percent were relative caregivers, and 4.9 percent was another relative. Fifty-four percent of the complaints were conveyed by mandated reporters.



Of the 162 complaints identified for Cohort B this quarter, 58 were rejected at intake. QA analysts found that all rejections met policy criteria and were appropriately rejected. The above graph identifies the reasons for rejections.



One hundred-four complaints received full investigations and disposition. One foster child was involved in an investigation that was opened as a Category III, "open/close," for improper supervision. The caregiver is an unlicensed relative and based on the case review, the investigation was completed appropriately and the current placement appears to be in the best interest of the child. Provided services included a Permanency Planning Conference (PPC), the establishment of a backup day care plan that continues to be utilized, and additional community resources.

One CPS case was opened and substantiated as a Category II. The identified child is a sibling to two other children whose cases were previously reviewed by the QA unit. Due to a data error, this child's case was not reviewed at the same time as the siblings. The identified child's case was reviewed this report period. As noted in the 2010 Quarter Three state report, there were some noted case management concerns relating to policy compliance errors, and these were addressed with the local office at that time. The QA reviews found that foster care is providing the caregiver with services and the adoption is currently on hold until all of the allegations involving the caretaker have been addressed. Despite the numerous complaints and the one substantiation, the foster care worker, courts and the MCI superintendent have all reviewed and evaluated the appropriateness of this placement and a determination was made that the children would remain in the care of the relative with services. The courts have also assigned the youth a Guardian ad Litem in order to ensure that all decisions made are in the children's best interest.

The safety of the child was the primary focus of the QA reviews for this cohort. Of the cases reviewed this quarter, only the above-mentioned re-reviewed Category II case was noted as having a possible safety concern. QA has noted that CPS investigations continue to be completed appropriately and there were no concerns for the safety of the children.

## **Quality Assurance Assessment: Cohort B**

Communication among programs (CPS, foster care, licensing), and documentation of that communication, remain consistent areas of concern for this cohort. This finding has been documented in every special review of higher risk cases state report published by the QA unit. Failure to recognize this communication issue could indirectly affect the safety and well-being of the children in care. The QA unit has made recommendations for improvement, and action steps are in progress.

Of the cases reviewed in Cohort B this quarter, 75.9 percent of the CPS case files contained documentation that contact was made with the assigned foster care worker. This number has fluctuated over the past year, which supports a need for consistent case management and supervision.

Of the cases reviewed this quarter, the correlating foster care service plan documented that a CPS complaint had been made and investigated for 35.2 percent of the complaints. This percent has been very consistent during all of 2010.

The DHS-154, Investigative Summary, is another important communication tool. Throughout 2010, the QA unit found that less than 30 percent of the foster care case files included the DHS-154. For the current quarter, only 23.8 percent of the investigated complaints had a copy of the CPS Safety Assessment and the DHS-154 in the foster care case record.

QA has made quality improvement recommendations regarding the findings noted during case reviews through exit interviews with the county managers, county summaries and state reports. These recommendations have resulted in local office changes and state-level evaluations of policy and training. New policy on proper CPS complaint documentation within the service plan is scheduled to take effect on June 1, 2011 to include specifications regarding mandatory documentation within the foster care service plan and the DHS-154. Additionally, Maltreatment in Care (MIC) units have been established in every urban county and in regional areas, and policy specific to MIC unit procedures was recently released. Through these developments, it is anticipated that the communication concerns will be addressed. The QA unit will continue to monitor the progress in

this area by completing case reviews of the MIC unit investigations and through data collecting.

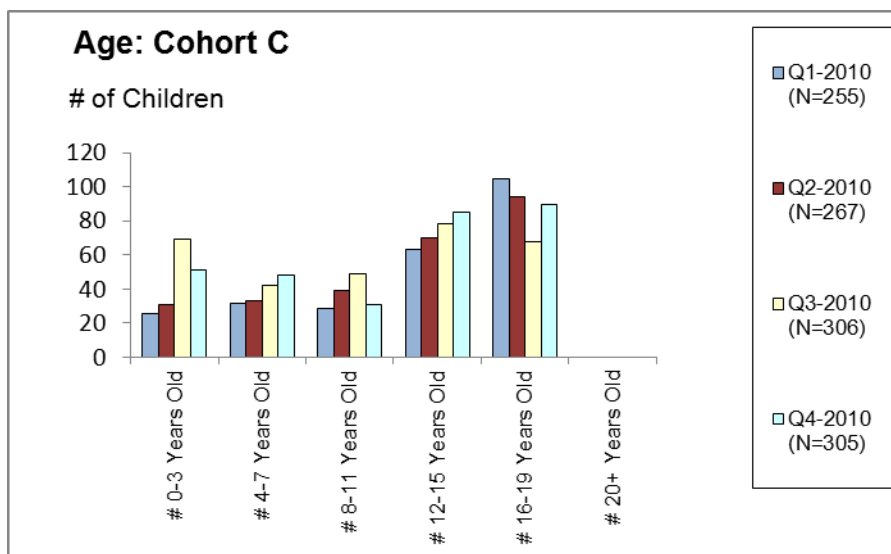
## Results: Cohort C

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

The Data Management Unit identified 2,388 cases that met the definition for this cohort in the 10/1/2010 data pull.

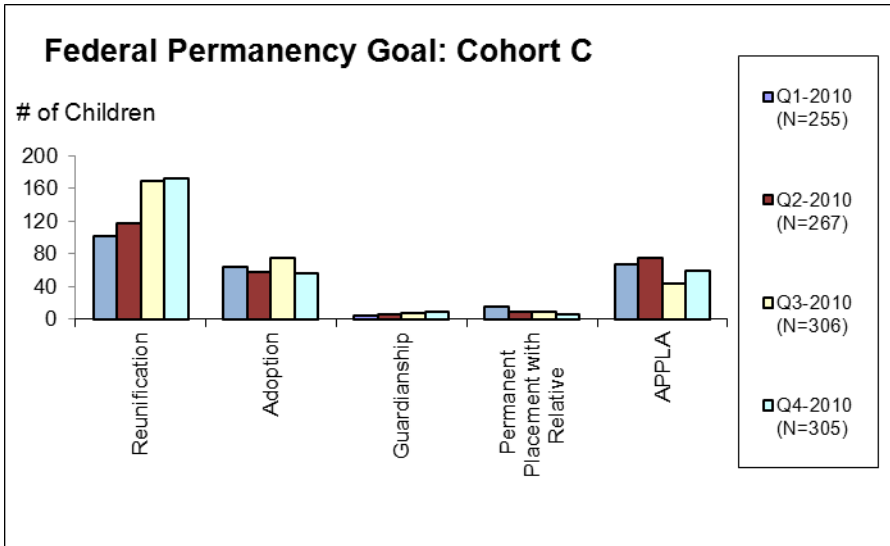
- Of the 2,388 cases, 1,002 cases were previously reviewed by the QA unit or it was determined that the case did not meet the requirements of Cohort C at the time of review. After excluding these cases, 1,386 cases remained eligible for review.
- QA utilized a web-based sample size calculator, called Raosoft, to determine a statistically significant sample size of 306 cases for this cohort. A data error occurred during the review process, resulting in one case being erroneously deleted from the sample. Ultimately, QA completed a comprehensive review of SWSS and the case file for 305 cases.
- One hundred eighty-two of the 305 cases were under the direct responsibility of DHS and 123 were under the direct responsibility of private child placing agencies.
- One hundred sixty-two of the children were female and 143 were male.

*The following five graphs offer a demographic comparison of the children identified in this cohort for all review periods in 2010.*

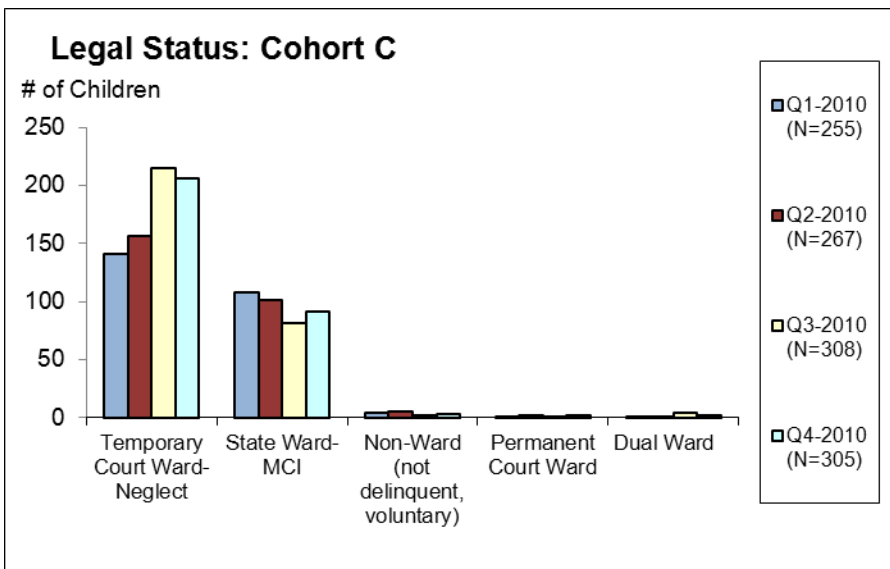


The above graph illustrates the ages of the children identified in this cohort. The QA unit has not identified a significant pattern or trend when comparing the ages. The median age of the children in this cohort is as follows:

- 2010 Quarter Four: 13 years
- 2010 Quarter Three: 11 years
- 2010 Quarter Two: 14 years
- 2010 Quarter One: 12 years

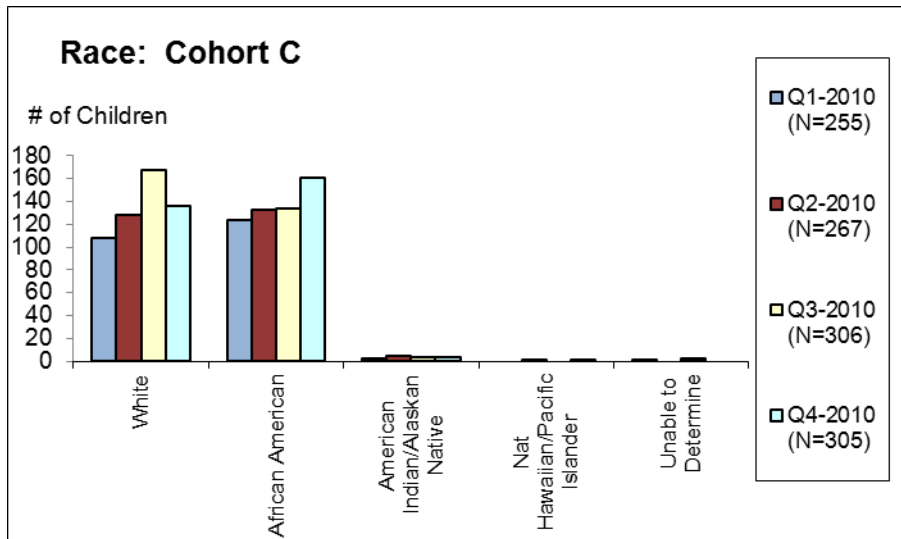


The above graph identifies the federal permanency goals of the children identified for this cohort for the four quarters in 2010. Reunification continues to be the prominent permanency goal for the children identified for this cohort. Furthermore, the number of children with a permanency goal of reunification has continually increased.

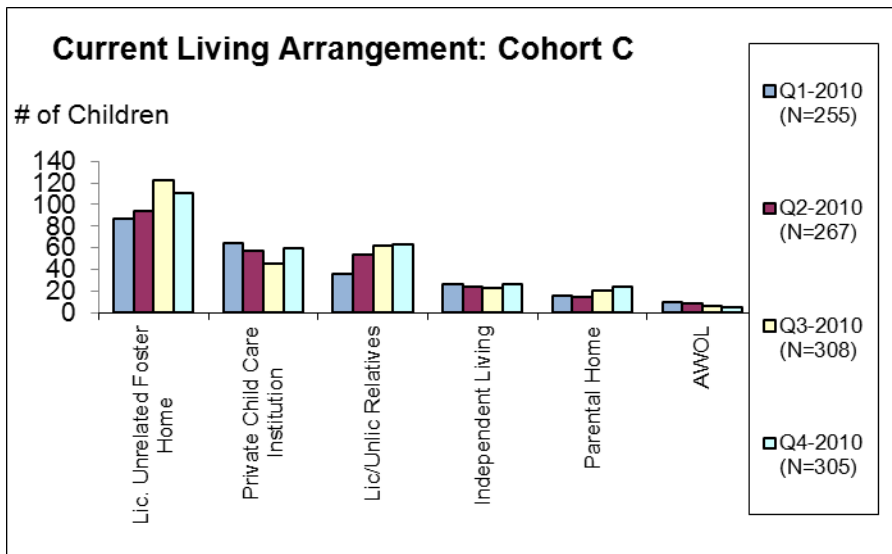




The above graph identifies the legal status of the children identified for this cohort in 2010. A legal status of temporary court ward has been the prominent legal status for the children identified in this cohort throughout all reviews completed in 2010.



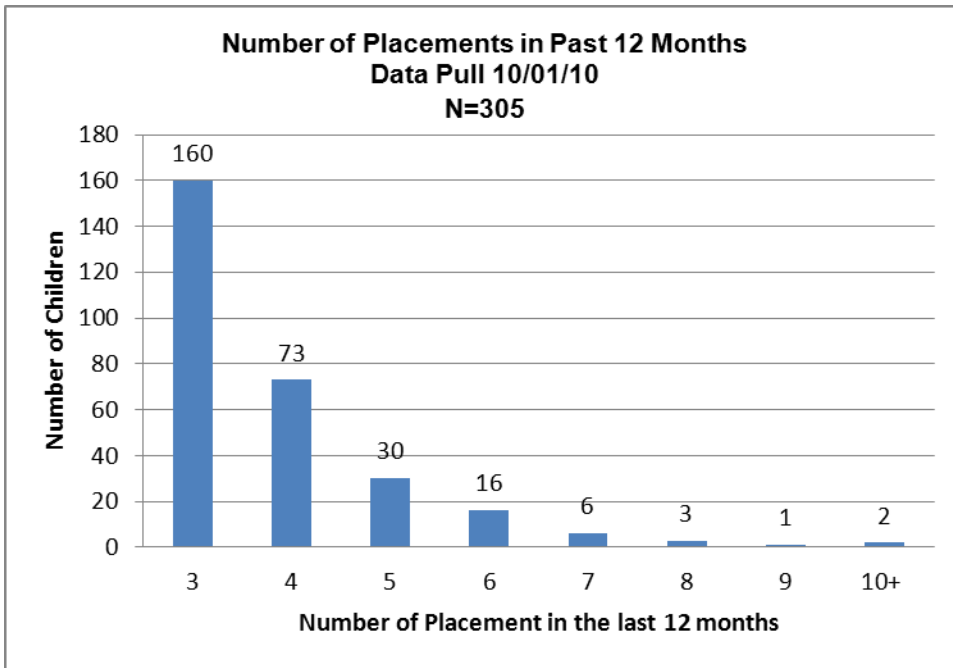
The above graph illustrates the represented races for the children in this cohort. The races of the children identified for this cohort have proportionally remained about the same through the past year. No specific race has been disproportionately represented in this cohort.



The above table compares the living arrangement of each youth at the time of review. As noted in the table, placement in private child care facilities (residential treatment) is consistently the third most frequent placement type.

The percentage of youths placed in private child care institutions for this cohort is 19.7 percent. This percentage is significantly higher than the state child welfare population, which is 5.2 percent. Furthermore, the number of current placements in these residential settings for this cohort has increased by 4.7 percent since last quarter.

*The following graphs outline cohort-specific information for the cases reviewed this quarter.*



The above table illustrates the number of placements in the past twelve months for the children identified in this data pull. The average length of stay per placement is four months. This has remained consistent throughout 2010.

### Quality Assurance Assessment: Cohort C

Of the 305 foster care cases reviewed, there were 1,115 total placements over the past 12 months.

The most frequent finding for this cohort was the lack of documentation of preparation for replacement and reasonable efforts to prevent the replacement. This finding has been noted in every Quality Assurance state report since Cohort C reviews began in September 2009 and continues to be a noted area of concern this quarter. Foster care policy on placement/replacements, FOM 722-3, describes in detail the need for stability and permanency when placing and replacing children in foster homes; however, foster care policy on updated

service plans does not currently require the worker to list reasonable efforts to *prevent* replacement. It appears that this missing element in policy has resulted in staff omitting this important documentation. Without this information, the QA unit is unable to ascertain if the worker has failed to provide services to prevent replacements or if DHS is lacking the proper services to meet the special needs of these children in order to stabilize their home setting. This neglected documentation also hinders supervisory oversight to ensure that appropriate services are in place. This could result in duplicated services that are not effective or services that do not address needs. The QA unit has made recommendations to program office regarding this concern. New policy is in development for release on June 1, 2011, which will address proper documentation of efforts to prevent replacements.

For the 10/1/2010 data pull, the DHS-69, Action Summary, is the required form used whenever there is "action" on a case, including but not limited to a child replacement. For this quarter, the QA unit reviewed 305 cases that involved 1,115 placements over the past year. Of those placements, a copy of the Action Summary was filed 63 percent of the time. In many cases, the Action Summary was found in the case file, but the form was incomplete or included invalid information. Missing or incomplete Action Summaries is a supervisory oversight on existing policy and compliance with this has to be monitored more closely on a local level. Future QA unit duties will include foster care case reviews, which will include continued monitoring of the Action Summaries. It will also be recommended this quarter that a procedure be implemented in the field offices requiring routine supervisory case reviews in order to assist in monitoring compliance with this current policy.

The QA unit also found substandard information on efforts to locate and place with relatives. This information is required both within the body of the service plan and via the DHS-987, Relative Notification form. The Relative Notification form is used as a comprehensive and continuous source of information regarding all possible relatives that have been identified for a youth. This form is an excellent tool for staff, not only to monitor which relatives have been considered in the past, but also for future reference for any staff newly assigned to the case. Over the past three quarters, less than 25 percent of the case files included the mandatory Relative Notification form. It does not appear that the current format of the DHS-987 is driving the staff to document relative contacts.

Through continued recommendations and Quality Improvement Plans, the QA unit is working to make sure that all counties recognize the importance of family involvement and the benefits of appropriately documenting all relative information on the DHS 987. In this quarter and last, 75 percent of the service plans were found to include information outlining efforts to contact relatives. However, based on the QA case review assessments, the quality of that relative search documentation remains inconsistent. Some service plans were found to include comprehensive and detailed documentation of efforts to contact and involve

relatives in the child's case planning, while other service plans included only vague references to relative notification, such as "There are no known relatives at this time." These vague references are often found to be repeated from service plan to service plan with no supporting information in the social work contacts or case file to verify what efforts were made to search for relatives.

The two most commonly noted reasons for replacement for the youth in this cohort were 1) at the caregiver's request due to the child's behavior, and 2) to move the child to a more restrictive setting as a result of his or her behavior. This has been a noted trend over the last three quarters. Due to the lack of documentation of efforts to prevent replacements, it is difficult for the QA unit and program offices to properly assess if a lack of services is in fact affecting the stability of these children in care, and if this correlates to the high percentage of placement changes due to behavior. QA has made recommendations to develop additional resources to preserve foster care placements, as such preventative behavioral and family services will help maintain placement stability. However, as stated above, until there is clear documentation, the QA unit will not be able to measure success rates on the actions taken in this area.

Along with permanency and well-being, the safety of the children is always assessed for the cases reviewed in this cohort. There were no imminent safety concerns noted for this cohort.

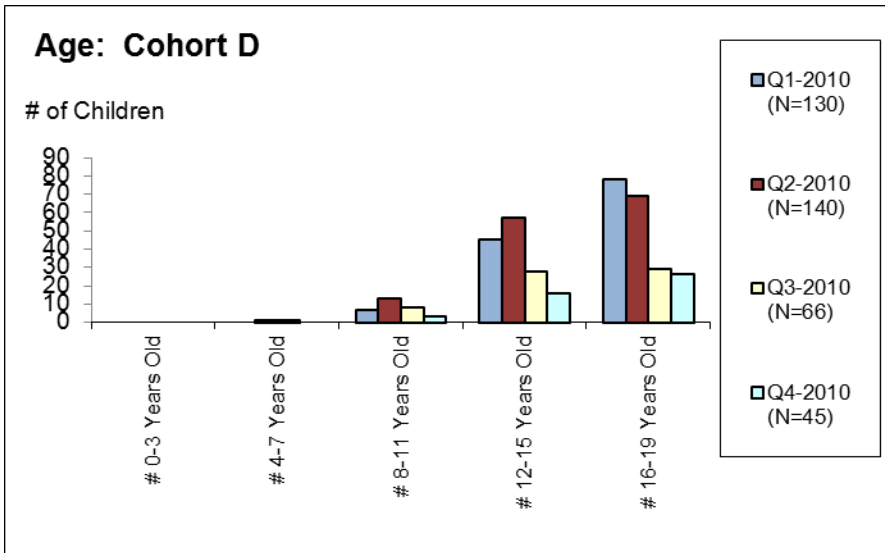
## Results: Cohort D

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

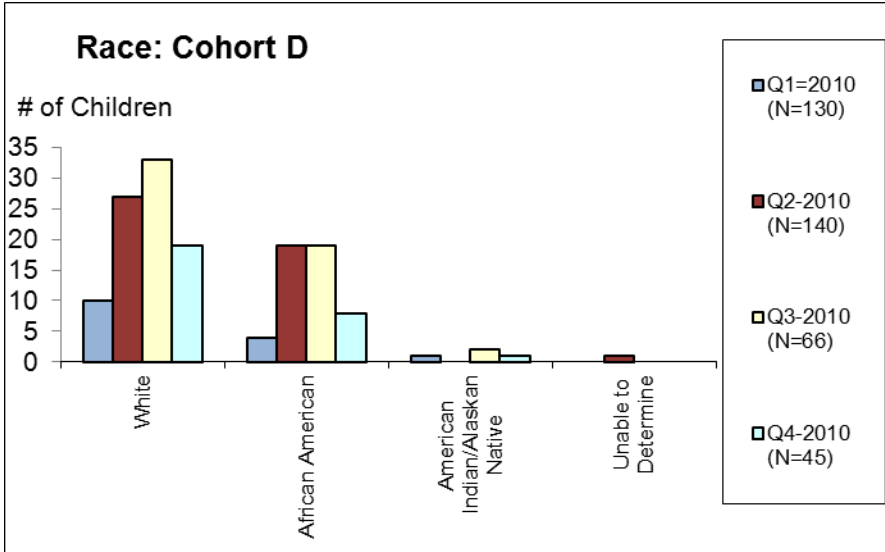
Three hundred-two cases were identified as meeting the definition for this cohort in the 10/1/2010 data pull. After the CQI analyst screened each case and determined eligibility, 45 cases were reviewed for this cohort.

- Two hundred fifty-seven of the 302 cases were either previously reviewed by the QA unit or it was determined that the case did not meet the requirements of the cohort at the time of review.
- Forty-four cases were under the direct responsibility of DHS and one was under the direct responsibility of a private child placing agency.
- Twenty-nine youths were male and 16 were female.
- The average length of time in the current residential placement for the cases reviewed was 11.2 months and the median was 14 months. The longest amount of time was 16 months.
- The average length of *total* time in residential settings for these children was 23 months.
- Thirty-four of the 45 youths had previous residential placements.

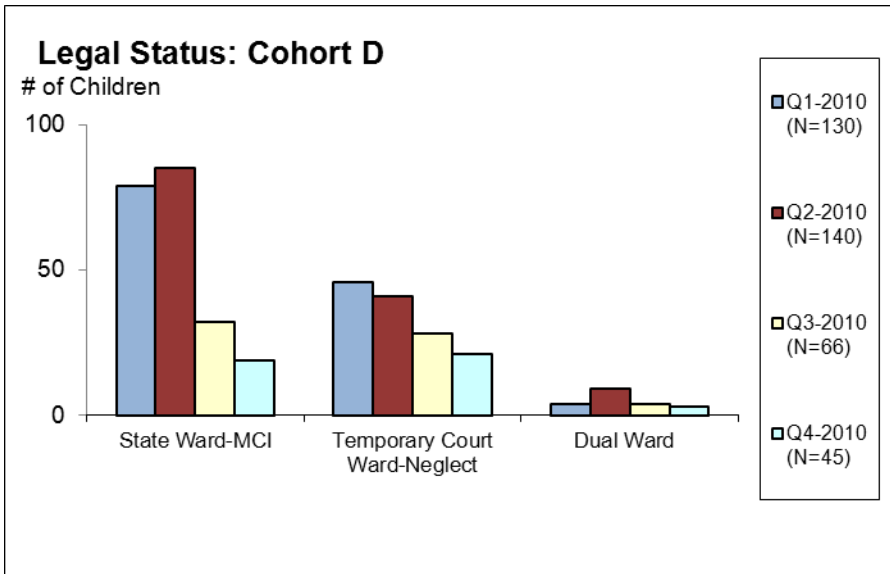
*The following four graphs offer a demographic comparison of the children identified in this cohort for all review periods in 2010.*



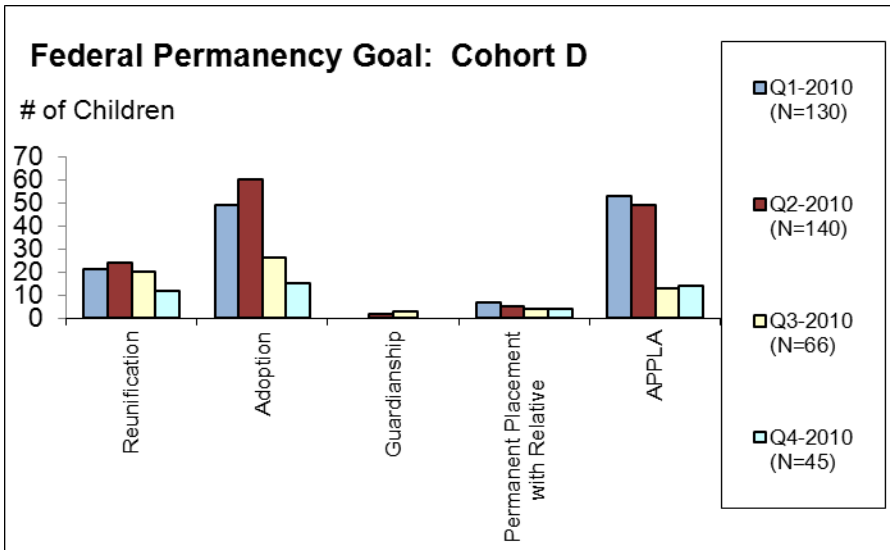
The above graph illustrates the ages of the youth identified in this cohort. For this quarter, the median age of the children in this group was 16 years. This is older than all of the other special review cohorts and is eight years older than the median age of the children in the child welfare population, which is eight years. This large gap in median age has remained a trend throughout all cases reviewed in 2010.



The above graph illustrates the represented races for the children in this cohort for each quarter in 2010. The races of the children identified for this cohort have proportionally remained about the same through the past year. No specific race has been disproportionately represented in this cohort.



The above graph identifies the legal status of the children identified for this cohort in 2010. Legal statuses of temporary court ward (TCW) and state ward-MCI are most often represented. The legal statuses of the children have proportionally remained the same throughout all reviews completed in 2010.



The above graph identifies the federal permanency goals of the children identified for this cohort in each quarter for 2010. Another planned permanent living arrangement (APPLA), reunification, and adoption are the permanency goals most often identified.

## Quality Assurance Assessment: Cohort D

During the reviews over the past year, QA noted that a large number of youths in this cohort have serious behavior problems that warrant the placement in a residential facility. The median age of the youths in this cohort is much higher than the other cohorts, as noted in the graph "Age of Children: Cohort D," above. Of the youths that are 14 years old or older, 80 percent have permanency goals other than reunification, and 31 percent of the youths in this cohort have permanency goals of APPLA or APPLA-E (emancipation). Based on the youths' needs, ages, federal permanency goals, and the lack of another appropriate placement setting, this could lead to a pattern of older youths aging out of foster care directly from the residential setting.

In Quarter Two and Quarter Three, the QA unit found a pattern of counties allowing their DHS-direct foster care staff to use a residential Updated Service Plan (USP) in lieu of the required DHS USP. The DHS service plan is required for documentation of certain elements of the case planning that are not required in the residential service plan. Local quality improvement plans were required in each of these counties and subsequently, this quarter the QA unit has found a significant improvement: only one of the 45 cases reviewed was missing an updated supplemental service plan.

Documentation of reasonable efforts to achieve permanency is mandated by federal guidelines. These guidelines are outlined in foster care policy FOM 722-6, Reasonable Efforts. Without documentation of reasonable efforts in the DHS service plan, it is difficult to determine if these youths and their families are being provided services to help move the child to permanency. Reasonable efforts to finalize permanency include, but are not limited to, providing services to the child and family and efforts to locate relatives for placement and/or support.

Of the 45 cases reviewed for this cohort, 95.5 percent included documentation of services provided to the youth and/or the family, while only 26 of the 45 cases (57%) included documented attempts to locate relatives. Relative notification information was collected for all of the cohorts, and it was found that for the children identified for this cohort, the frequency in which workers continually documented efforts to involve relatives were is lower than the other high risk categories. This supports the finding that our children with prolonged residential placements have less familial support than other children in care.

Foster care policy FOM 722-6, Relative Notification, states that throughout the case, the foster care worker must continue to seek, identify, and notify relatives *until legal permanency for the child is achieved*. As in Cohort C, the case reviewers found there was an inconsistency in the quality of the documentation of efforts to locate relatives for support and/or placement of these youths. Quality Assurance analysts are finding documentation that is repetitive word for word in each service plan, or the information is not supported in other sections of the report. A thorough, all-inclusive relative search could not only help prevent



multiple moves, but it also provides improved support systems, and incentives to achieve service goals that could result in discharge from the residential placement. Based on these findings the QA unit has addressed this relative notification issue through local office QIPs and continued monitoring of this area.

Along with a low frequency of documentation of attempts to contact relatives, most of the cases in this cohort did not include the important Relative Documentation form, the DHS-987. Only three of the 45 cases reviewed in this cohort had a DHS-987 in the case file. As noted in Cohort C, the DHS-987 is an excellent tool for staff, not only to monitor which relatives have been considered in the past, but also for future reference for any staff newly assigned to the case.

Twenty-four of the 45 cases (53%) reviewed in this cohort included a current approved, or copy of a pending approval, residential placement exception request in the case file. The consent decree states that “no child shall be placed in a residential treatment center without express written approval by the county administrator of Children’s Services in a designated county, or by the Children’s Services Field Manager in any other county.” (Section X.B.7, Limitations on Residential Care Placements.) It was found that the most pertinent and detailed information about the child’s history and reason for the need for residential was actually found in the residential placement waiver and not in the DHS service plan. This is a concern as the waiver is a supplemental form and should not replace the mandated information in the service plan.

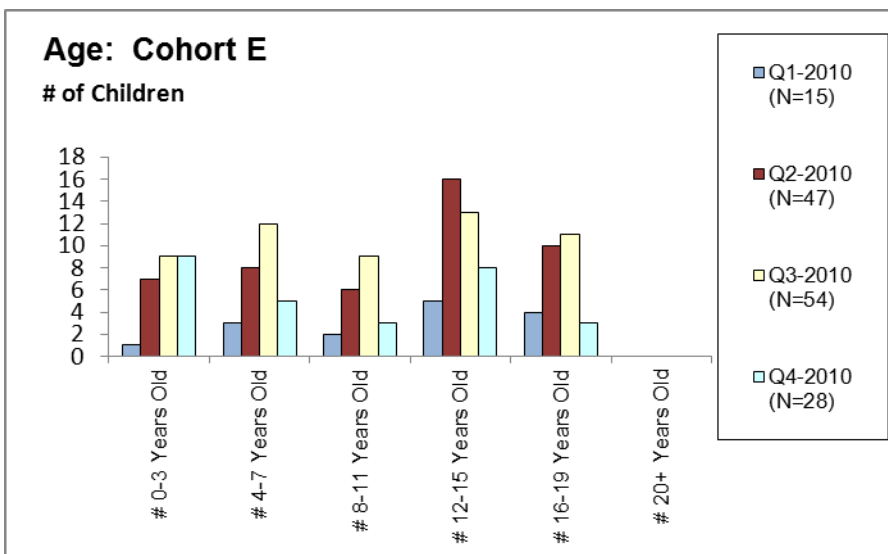
Along with permanency and well-being, the safety of the children is always assessed for the cases reviewed in this cohort. There were no imminent safety concerns noted for this cohort.

## Results: Cohort E

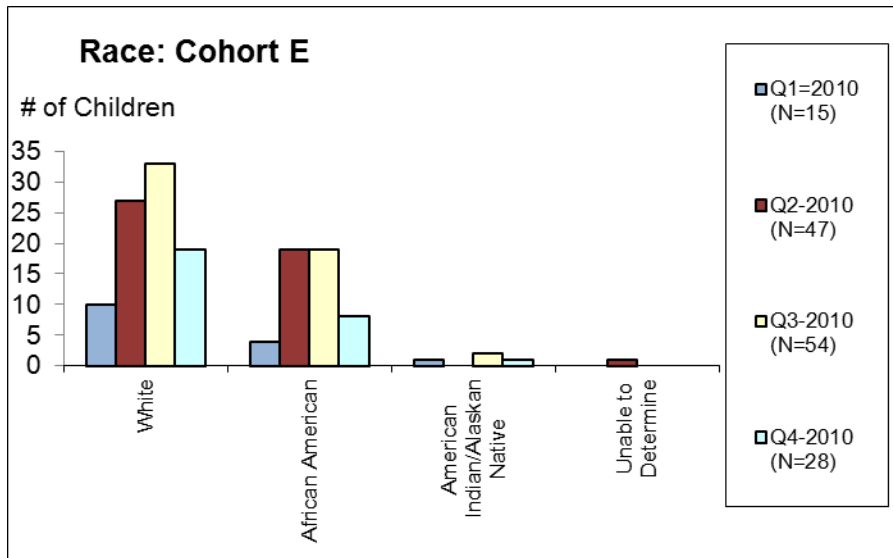
*Definition: Children who, at the time of review, are in an unrelated caregiver placement, defined as an unlicensed home in which the caregiver is not a relative of the child but has been approved as a placement resource because of prior ties to the child and/or the child's family.*

One hundred twenty-nine cases were identified as meeting this cohort on the 10/1/2010 data pull. Ultimately, the QA unit completed a comprehensive review of the Services Worker Support System (SWSS) and the physical case file record for 28 cases.

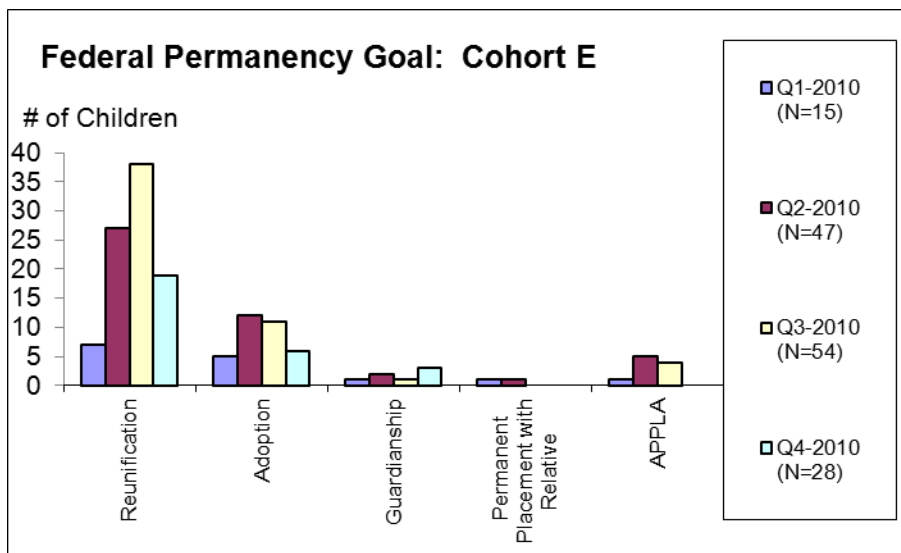
- One hundred-one cases were either previously reviewed by the QA unit or it was determined that the case did not meet the requirements of cohort at the time of review.
- Thirteen children in this special review category were male and 15 were female.
- Twenty-one of the children were temporary court wards, six were Michigan Children's Institute wards and one was a permanent court ward.
- Twenty-six of these 28 cases were under the direct responsibility of DHS and two were under the direct responsibility of private child placing agencies.



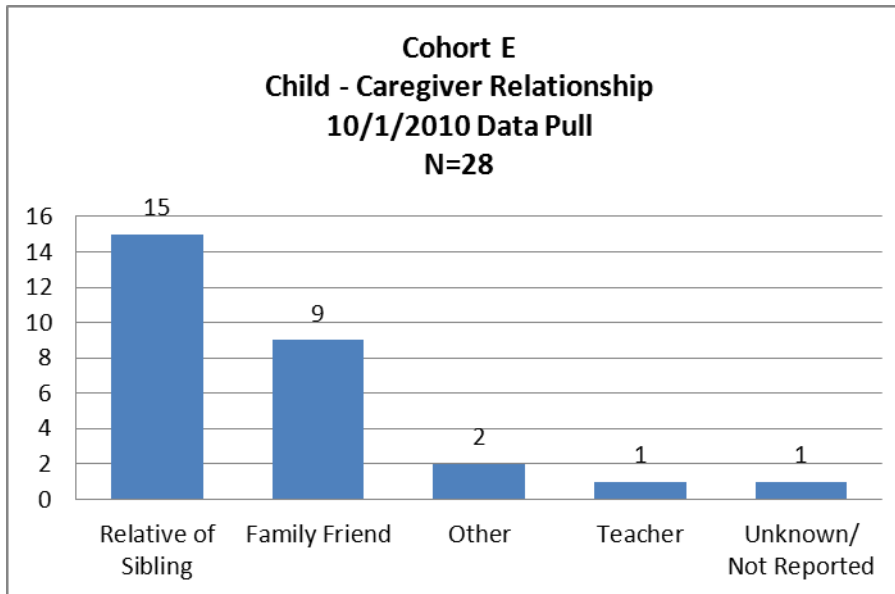
This chart compares the ages of the identified for Cohort E this quarter against the ages of the prior three quarters in 2010. The QA unit has not identified a significant pattern or trend when comparing the ages. The proportion of ages of the children identified in this cohort has remained steady throughout the 2010 reviews.



The above chart illustrates the represented races for the children in this cohort. The races of the children identified for this cohort have proportionally remained about the same through the past year. No specific race has been disproportionately represented in this cohort.



The above graph identifies the federal permanency goals of the children identified for this cohort for 2010. Reunification is consistently the most frequent federal permanency goal for the children identified for this cohort.



The above graph illustrates the child-caregiver relationship for the cases reviewed this quarter. Only one case was lacking documentation that the child was placed in a home where a significant relationship existed. Eighty-six percent of the children are placed with relatives of siblings or with family friends, indicating that these placements are in the children's best interest.

The high percentage of placement with siblings' relatives or family friends has not only been consistent throughout prior reviews, but that percentage has increased by 36 percent since the QA unit began tracking this information in April 2010. At this time, the QA unit has been unable to determine the specific reason for this increase.

## Quality Assurance Assessment: Cohort E

Child safety and permanence are primary factors of the QA reviews for this cohort. Of the 28 cases reviewed this quarter, only two placements included CPS involvement while the child was in the care of the unrelated caregiver. In one case, the complaint was appropriately rejected at intake as there were no allegations of child abuse/neglect against the caregivers. In the second situation, a CPS complaint was substantiated due to the foster parent utilizing an inappropriate babysitter. DHS provided services and continues to monitor this placement.

As noted in the 2010 Quarter Three state report, home studies were not always completed and/or filed within the case file. Eight of the 28 (26.6%) cases

reviewed this quarter also lacked documentation of a home study on a DHS-197, Relative Caregiver Home Study Outline. In order to ensure the child's safety in those homes, QA verified that for every case that was missing a home study, the local office had determined through some other means that the living conditions were safe but the worker had failed to fill out the actual DHS-197 form.

QA noted other missing documentation as required by current policy, but the case review found the youth to be safe despite this non-compliance. The documentation of approval by the local office director was missing in 11 percent of the cases and 53.6 percent of the court orders were missing the required wording authorizing the placement. In the 2010 Quarter Three report, QA made recommendations to the foster care and CPS program offices to review current policy on unrelated caregivers and assess it for consistency and effectiveness. CPS and foster care program offices have initiated action to address the policy inconsistencies. Uniform policy will ensure collaboration between programs to expedite all actions necessary to ensure the children's safety.

In 26 of the 28 cases (92.9%), the latest service plan documented that the placement is in the child's best interest (most family-like setting, maintains familial relationships, child able to remain in the community/school), and 21 of the 28 cases (75%) included documentation of continued efforts to locate relatives.

Based on the data collected over the past year, the QA unit maintains that these placements with unrelated caregivers are safe and have been in the children's best interest.

## Conclusion

The Quality Assurance system is driven by the department's commitment to delivering high quality services that provide functional, positive outcomes for the children and families we serve. The QA unit is required to perform reviews of higher risk cases to look for patterns or trends and to make appropriate recommendations based on the findings. Analysis of the information gathered from these reviews continues to indicate an on-going need for improved case management, training, and supervisory oversight.

Throughout the last year the QA unit has made recommendations based on the findings of the special reviews. Action steps are in place to either enhance or change policy to assist staff with the case management of these cases and the Child Welfare Training Institute (CWTI) has also begun to make changes to their training curriculum to address possible lapses in staff and supervisor training. Furthermore, foster care program office is looking at policy to specifically identify where certain case events should be documented. Through individual county reviews and feedback, field offices are also making efforts to develop plans at a local level in order to enhance case management and supervision. Training and policy is only the first step; local office implementation of that policy and training is essential.

QA reviews indicate the need for the implementation of more supportive services in foster homes, whether licensed, relative, or unrelated. It is noted that stability and permanency are disrupted due to a lack of support in the home, often due to a child's behavior. Providing a more structured support system for the foster parents may result in a reduction of placement changes and, more importantly, may encourage some foster families to have youths with special needs placed into their homes. These services could also provide more placement opportunities for older youths to help prevent them from aging-out while in residential settings. Identifying available services for the high risk youth is important, but it is essential that the field workers then utilize the available services and properly document this in the service plans.

The QA reviews also found that diligent contact with relatives and *thorough* and *quality* documentation of those relative contacts are also essential to achieving permanency for youth in care.

Finally, the QA reviews indicate the need for open communication between service programs and among child placing agencies is another area in need of improvement. Deficient communication and *documentation of that communication* can have a direct effect on safety, permanency, and well-being.

## Recommendations

The following recommendations are the comprehensive result of recommendations made from all cohort reviews.

### Field Office Administration:

- Explore a best practice protocol with local offices that addresses the completion of relative forms. Consider utilizing the PPC process as relatives are often in attendance at the PPCs and this is an opportunity to gather important information and reduce redundancy of casework.
- Consider implementing a foster care supervisory case review procedure, one that is similar to the current CPS process that requires quarterly supervisory case reviews.

### SWSS/SACWIS:

*Given that efforts are afoot to develop the new SACWIS system, recommendations should be taken under advisement while the system is in development.*

- Consider expanding the use of ticklers or other similar functions in SWSS-FAJ to better remind staff of required actions wherever possible. For example, a change in the SWSS placement module to living arrangement "08" (unlicensed, unrelated caregiver) should generate a reminder and reference to the several requirements in policy for an unlicensed, unrelated placement.
- Consider updating the SWSS transfer process from CPS to foster care to require an entry regarding the Relative Documentation form (DHS-987). PSM 715-2 requires CPS to initiate the form following any emergency removal. SWSS should require, minimally, a Yes/No entry as to whether the form was required and, if yes, whether it was included in the materials given to foster care.
- Consider modification to the Placement section of SWSS-FAJ so that it includes mandatory fields for detail about efforts to consider a relative or parent for placement at the time of a child's move and requires information about services provided to prevent replacement and services needed to make the next placement successful. This should then be populated directly into the Action Summary (DHS-69).

- Consider connecting the PPC database to the SWSS system to reduce redundancy and have all PPC recommendations populate into the USP section regarding child status.

## Follow Up

DHS continues to implement policies and develop training aimed at improving the quality of service to children and families in the child welfare system. As a result of prior recommendations made by the Quality Assurance unit, the following steps have been taken by DHS, since last quarter's case reviews.

- A recommendation was made to review and implement policy requiring a Permanency Planning Conference to occur when a child has been ready for discharge from residential placement for more than 30 days and sufficient progress has not been achieved to transition the child to a less restrictive setting. At the end of 2010 DHS issued L-Letter L-10-133-CW and an interim policy bulletin requiring the recommended PPC.
- A recommendation was made to consider modifying service plan policy to include mandates for documenting efforts to prevent replacements, or documenting the reason why reasonable efforts were not necessary, if applicable. FOM 722-9D, Permanent Ward Service Plan, has been amended to include guidelines to include any replacements during the report period, the efforts made to prevent these replacements, and the child's feelings and observations about the current placement. This new policy is scheduled for release on June 1, 2011.
- A recommendation was made to modify policy to ensure that service plans document any CPS complaints regarding the child's caregiver. FOM 722-9D has been amended to include that information in the "Best Interests of Current Placement" portion of the service plan, including documentation of any foster home licensing complaint investigations. This new policy is scheduled for release on June 1, 2011.
- A recommendation was made to amend PPC policy to include proper filing of the DHS-969, Permanency Planning Conference Facilitator Report, the DHS-971, Permanency Planning Conference Activity Report, and the DHS-968, Permanency Planning



Conference Attendance Report. Policy was amended on 1/1/2011 to include this information.

- A recommendation was made to CPS and foster care program offices to collaborate on consistent policy on unrelated, unlicensed caregiver placements. Program managers have discussed this issue at length and new policy efforts will be implemented.