Select Recurrent and Developing

Quality Assurance/Quality Improvement Activities

January 2016

CT Department of Children and Families (DCF)

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Purpose Statement

There are myriad qualitative activities occurring throughout the Department. As a means to better understand what is occurring and to facilitate greater coordination of such work, the DCF Chief of Quality and Planning requested that the Department's Administrators, Superintendents and Division Heads/Directors to identify all the recurrent quality assurance/improvement activities that are happening, and those that are slated to launch shortly.

This cataloging should is intended to create a window into the various activities that are occurring throughout the Department to assess whether our core functions, initiatives and services are well implemented and are producing positive outcomes. This information is also critical to our Statewide Assessment for the upcoming Federal Child and Family Service Review (CFSR), and towards building the components of an agency-wide Quality Assurance Plan.

Items to Be Addressed in the Quality Assurance Summary

This request identified that each summary should, at a minimum, addresses the following:

1. What recurrent QA/QI activities are happening?
2. What results are each activity intended to achieve?
3. How frequently do each of the activities occur?
4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?
5. What methodologies are used for each activity?
6. If applicable, what is the universe and sample size?
7. What data is collected?
8. Where is the data housed?
9. What types of analyses are done?
10. How are the attending data/reports disseminated?
11. Are data/reports shared with staff and providers?
12. How are the findings from each activity used to inform change?

Office for Research and Evaluation Quality Assurance Summary: Recurrent Activities

There are many recurrent quality assurance activities happening within the Office for Research and Evaluation (ORE). Each of these activities is indicated below, in a stand-alone section.

Institutional Review Board

1. What recurrent QA/QI activities are happening?

   The Connecticut DCF Institutional Review Board (IRB) meets on a monthly basis and is responsible for reviewing and approving proposed research involving clients and staff prior to the initiation of research and through continuing review and monitoring of approved research studies.

2. What results are each activity intended to achieve?

   The purpose of an IRB review is to ensure that studies are being conducted in accordance with ethical principles of autonomy, beneficence and justice and to ensure the protection of the rights of human subjects throughout the research process.

3. How frequently do each of the activities occur?

   The formal IRB meeting occurs on a monthly basis to review initial research applications as well as amendments and/or continuations of previously approved research. In addition, at times IRB members are asked to participate in expedited reviews informally, outside of the time of the regular IRB meeting to support approval of requests that meet the expedited review definition.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Currently, the IRB is comprised of: an area office principle attorney, the DCF Director of Nursing, a regional resource group nurse, a private non-profit provider representative, a licensed clinical psychologist from an inpatient setting, a Central Office Program Manager and a Central Office Contracts supervisor. Prior to submission of an IRB initial application, it is expected that the Principle Investigator submits a Research Proposal Impact Assessment to the Office for Research and Evaluation for a review of the proposed impact on the Department. The Director of ORE, the lead Statistician and an ORE Program Manager are involved at that level of review prior to the application proceeding to the IRB.

5. What methodologies are used for each activity?

   Individual structured research application review.

6. If applicable, what is the universe and sample size?

   The universe and sample size are determined by what is received by the DCF IRB.

7. What data is collected?

Data is maintained identifying the names of studies, names of Principle Investigators, Date Received, Date approved, and Dates due for Continuation.

8. Where is the data housed?

Institutional Review Board web-site, IRB SharePoint site, the IRB Mailbox and the IRB System Drive.

9. What types of analyses are done?

We maintain a count of types of IRB applications approved, continued, and declined each year.

10. How are the attending data/reports disseminated?

Posted on the IRB SharePoint sites. Annual reports and final reports regarding research projects are posted on the IRB SharePoint site.

11. Are data/reports shared with staff and providers?

Research reports are posted and are accessible for staff and providers through the DCF IRB SharePoint site.

12. How are the findings from each activity used to inform change?

The Department seeks ongoing opportunities to engage in partnerships of mutual benefit as an outgrowth of its commitment to and investment in scholarly research. The Department may be able to make significant contributions to proposed research and build DCF staff capacity through involvement in activities such as formulating the research hypotheses and research design; and or designing or conducting data analysis and interpreting the findings. It is expected that studies that are conducted within DCF populations are culturally and linguistically responsive and appropriate and lead to inclusion and increased knowledge that is relevant to our heterogeneous population.

Private Non-Medical Institution (PNMI)

PNMI is a federal revenue initiative which allows Connecticut to submit claims for children receiving certain "rehabilitative services" while in placement in residential treatment centers[1] (RTC) and therapeutic group homes (TGH). The PNMI program allows DCF to capture and maximize federal dollars for Medicaid services.

PNMI Reviews

1. What recurrent QA/QI activities are happening

DCF PNMI review staff conduct on-site reviews of the treatment planning for all youth in placement at a respective facility. An in-depth review of the case records of two youth in placement at an RTC or one youth in placement at a TGH is also conducted

2. What results are each activity intended to achieve

[1] Residential Treatment Centers which never rise above a census of 16 are included within the federal initiative. Those with the capacity to rise above a census of 16 are also included in the DCF PNMI review, but are not eligible for federal PNMI purposes.

The review ensures that the performing provider meets and maintains all applicable licensing, accreditation and certification requirements in accordance with federal and state laws. The review is grounded in the PNMI standards and compliance requirements which are the structural components for achieving effective child specific rehabilitative service outcomes in support of restoring the child to the highest possible level of functioning and achieving the child specific discharge plan. There are thirty-five PNMI standards assessed during a PNMI review. Each review assesses and evaluates the quality of ongoing, rehabilitative services provided to the children in placement with the respective provider. The results of the activity include a treatment plan overview and comprehensive case review of one (TGH) or two (RTC) youth in placement. A PNMI review report is issued following each review, indicating the level of compliance for the respective PNMI program. When indicated, training and/or remedial training is provided, Service Delivery Plans (SDP) which were previously referred to as Corrective Action Plans (CAP) may be issued, and ongoing monitoring of the SDP occurs.

3. How frequently do each of the activities occur

PNMI reviews occur biannually, every six months.

SDPs are individually developed when needed and monitored at a frequency that is commensurate with the presenting issues. Areas in need of improvement which are identified in an SDP and then again in a consecutive PNMI review result in a higher intensity of monitoring and may result in a Corrective Action Plan.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))

PNMI reviews are conducted by Children Services Consultants, with a chain of command of a Social Work Supervisor, Program Manager, and Program Director.

5. What methodologies are used for each activity

A full review includes:

i. A review of LINK provider information and current placement information
ii. A Significant Events report for the Period Under Review is reviewed
iii. An on-site review is scheduled and occurs over a period of 2-4 days and includes:

- An entrance conference.
- Review of all treatment plans for any child who was/is in placement during the PUR.
- Comprehensive case review for a selected child in placement; one for a TGH, two for a RTC.
- On-site training when indicated based on review results.
- An exit conference.

iv. Issuance of final reports and requests for SDPs when indicated.

6. If applicable, what is the universe and sample size?

The universe is all children in placement during the PUR for the treatment plan overview review. For the comprehensive treatment plan review the sample is one (1) youth for a TGH or two (2) youth for an RTC.

7. What data is collected

Data collected is related to the compliance with the 35 PNMI standards and evaluation outcomes of *compliance* or *non-compliance*.

8. Where is the data housed?

   Data is house in the individual reports promulgated for each provider and stored on the ORE drive.

9. What types of analyses are done?

   Analysis is done for a provider when indicated based on the outcome of the current PNMI review.

10. How are the attending data/reports disseminated?

    Reports are disseminated to the respective provider via email.

11. Are data/reports shared with staff and providers?

    Reports are shared with the providers. Staff within ORE have access to reports on the ORE drive.

12. How are the findings from each activity used to inform change?

    The outcomes or *non-compliance* are used to convey areas needing Improvement to the provider and develop a SDP. Whereas, the outcomes of *compliance* are used to highlight quality practice and can also be used as de-identified examples for programs that are not achieving compliance in the respective standard.

PNMI Random Moment Time Study

1. What recurrent QA/QI activities are happening?

   PNMI Revenue Enhancement Project- Random Moment Time Study (RMTS)

2. What results are each activity intended to achieve?

   Provide data to DCF rate setting used to establish an accurate and supportable Medicaid claim rate for Private Non-Medical Institutions

3. How frequently do each of the activities occur?

   Continuous reporting and system support; quarterly sampling and aggregation of data; annual data reporting for DCF fiscal analysis

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Facility Participants; ORE Children's Services Consultant (CSC)

5. What methodologies are used for each activity?

   Automated email notification to staff and supervisor of an impending, passed, and expiring moment; web based data entry regarding activities performed during the sampled moment

6. If applicable, what is the universe and sample size?

   Universe: All staff in participating facilities for whom 25% or more of their work time involves direct client contact; Sample Size: 2,402 60-second moments per quarter plus 25% oversample

7. What data is collected?

   Date and time of the moment and the code for the activity performed during the moment. Facility staffing data is also collected.

8. Where is the data housed?

   Center for Healthcare Financing, University of Massachusetts Medical School

9. What types of analyses are done?

   Provider compliance and claimable activity are reviewed

10. How are the attending data/reports disseminated?

    Annual RMTS results are provided to DCF Rate Setting Unit as needed for rate determination; provider compliance reporting is determined by the PNMI workgroup which is currently inactive

11. Are data/reports shared with staff and providers?

    As requested

12. How are the findings from each activity used to inform change?

    RMTS results are critical in determining the rate of Medicaid reimbursement for selected congregate care services funded by DCF.

Foster Home Quality and Satisfaction Survey (FHQSS)

Hearing directly from foster children and their caregivers can provide critical client feedback on the foster care service delivery and improve our understanding of the impact of placement into out-of-home care. The Connecticut Department of Children and Families, however, has never conducted a statewide survey to hear directly from these children. DCF undertook the FHQSS as an ongoing qualtiy assuranace project beginning with a pilot in 2014 and the first survey in 2015. The objective of this work is to examine the level of quality and satisfaction of foster home placements as well as associated factors among foster children and their caregivers.

Methods: A random sample of children ≥ 8 years old who were placed in a foster home were invited to participate in a cross-sectional study. Data were collected through face-to-face interviews for 225 children and 221 caregivers (of which 12 secondary caregivers were excluded from the analysis); foster youth ≥ 13 years old were also asked to complete a supplemental self-administered questionnaire to assess their pro-social and potentially detrimental behaviors. Descriptive statistics were used to examine the level of quality and satisfaction.

1. What recurrent QA/QI activities are happening?

   The FHQSS is a recurrent activity that began as a pilot in 2014. The first full survey cycle took place between January through July 2015.

2. What results are each activity intended to achieve?

   The results of the data collected from the survey will suppport the agency in examining the level of quality and satisfaction of foster home placements as well as associated factors among foster children and their caregivers. Additionally, the agency may elect to evaluate practice and/or policy based on durvey results. Areas idetnfied as strengths and those needing improvement can inform the partnership with foster parents to support maximizing outcomes for children placed in foster care.

3. How frequently do each of the activities occur?

   Based upon ongoing discussions with the Senior Management and Regional Management, the frequency will be set. The current proposal is to conduct the survey annually.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   - The surveys are conducted by Children Services Consultants and Social Work Supervisors in partnership with CAFAP Liaisons.
   - Interns and light duty staff are also utilized to assist with scheduling activities.
   - Data analysis is conducted by a Statistician.
   - Report writing is a shared function within DCF of the Statistician and Children Services Consultants.

5. What methodologies are used for each activity?

   In-home surveys are conducted with children in foster care and foster parents. Prior to administering the survey, staff reach out to the Area Office to determine if involvement in the survey process is contraindicated for the child or foster parent. A permission to participate is also requested for any child to be surveyed. Scheduling then occurs to identify a time that is convenient for the home when the survey can be conducted on-site. During the on-site survey, all participants meet with the Surveyor who reviews the purpose, objectives, and describes what will take place during the actual survey. The survey is then administered to each participant individually, in a location that affords privacy. Foster Parents complete a *Foster Parent Survey*, all children complete a *Foster Child Survey*, and children ages 13 and older are given the option to complete a confidential *Supplemental Survey* focused on prosocial behavioral questions.

6. If applicable, what is the universe and sample size?

   The most recent universe was a random sample of children ≥ 8 years old who were placed in a foster home based on the parameters/assumptions of : 75% overall satisfaction rate, 4% margin of error, 95% level of confidence, 1,150 total children in foster home care and 75% participation rate. This resulted in a universe of 432 children. The inclusion/exclusion criteria for foster children and foster parents included:

   a) Placement type: The study involved only children in foster home placements.
   b) Age: The study excluded children younger than 8 years. Although children as young as the 5-year old age subgroup can reliably answer questions with an age-appropriate instrument, the reliability coefficients for the 5–7 age subgroups is still somewhat lower in comparison to the 8–18 age subgroups (Varni, 2007). For this reason, the study targeted foster children 8 years and older.

Additionally, only children who are 13 years and older were asked to complete the self-administered supplemental section. Given the nature of the questions, this age was set to ensure that youth answering the question had achieved a certain developmental and maturity level. Given that questions contained in the supplemental were derived from Connecticut Department of Public Health survey administered to youth in at least the middle school, we wanted to ensure that younger children were not exposed to sensitive topics.

c) Length of stay: Children needed to be in foster care for at least ninety days. The 90-day criterion was based on the engagement and assessment process toward the development of case plans. This timeframe allowed the DCF assigned staff to have sufficient time to engage and assess the child's needs thereby minimizing that the study revealed unknown information about the child's needs and behaviors.

d) Legal status: Children for whom DCF did not have guardianship (i.e., Order of Temporary Custody) were excluded. Only children under orders of commitment, dual commitment and for whom the DCF is statutory parent were included in the study. This ensured a uniform consent and assent process with the DCF as the legal guardian consenting to participation. Given the previously stated selection criterion of length of stay (in foster care no less than ninety days), the number of children excluded due to legal status should be small because it is less likely for children to be under orders of temporary custody.

e) All selected children's primary foster parent were invited to participate in the study. The primary foster parent referred to the parent who spent more time in caring for the selected foster child. However, as noted above, if a secondary foster parent elects to participate, he or she was permitted to participate in the study.

Future universes will be based on a smaller sample size that supports a 95% confidence level in an ongoing survey process designed to provide ongoing evaluation and assessment of quality and satisfaction.

7. What data is collected?

- Data is collected from LINK and the completed surveys. Data points collected include:
- Demographic information
- Household members
- Marital status
- Educational attainment
- Type of foster care – CORE or Therapeutic
- Employment outside of the home
- Responses to survey questions

Additional data points available through LINK can be collected, i.e. invitation to an Administrative Case Review (ACR), attendance/participation in an ACR.

8. Where is the data housed?

The survey data is house on the DCF ORE site in SharePoint. Data extractions from LINK and the compilation of all survey data are housed on the ORE drive.

9. What types of analyses are done?

Analyses are done on all questions within the surveys. Additional analyses can be done if requested and supported by the available data, i.e. *what percentage of foster parents report their race as white based on the survey as compared to data in LINK.*

10. How are the attending data/reports disseminated?

Data and reports are disseminated electronically through email distribution lists and the ORE SharePoint website.

11. Are data/reports shared with staff and providers?

Macroscopic data is shared within the agency with senior and upper management for their dissemination. Additionally, this data is shared with stakeholders and partners such as CAFAP and the Youth Advisory Board. Specific data is shared with those within the agency, and potentially outside, when indicated.

12. How are the findings from each activity used to inform change?

The findings are used at the discretion of agency management to inform change. An example of this is the data related to sibling visitation in the recent FHQSS. This finding is being used with other information related to sibling visitation to inform agency practice in achieving the desired results for frequency and quality of sibling visitation.

Exit Outcomes Measures

Outcome Measure 10: Sibling Placement

1. What recurrent QA/QI activities are happening?

Case reviews are conducted on a quarterly basis in order to determine compliance with the Exit Outcome. The report is completed and submitted quarterly to the Office of the Court Monitor based on a calendar year.

2. What results are each activity intended to achieve?

Full-fill the reporting requirement of the Juan F. Consent Decree and demonstrate the Department's compliance and case practice regarding placing siblings together and any barriers. The standard to be met is 95% of children in care with siblings in care are to be placed with all of their siblings unless there is a clinical reason why they are placed separately.

3. How frequently do each of the activities occur?

The case review occurs on a quarterly basis evaluating the previous quarter's results and the reports are completed and submitted quarterly.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

Case Reviews: Social Workers, Children Services Consultants, Social Work Supervisors

Data Analysis: Report Writing and Submission: Social Work Supervisor

5. What methodologies are used for each activity?

Universe: The Universe consists of all Juan F. children in care. The sample is created by combining the Child in Placement Link Report and the previous Quarter's review results using Excel and ACCESS. It consists of all children in care during the quarter who also had a sibling in care at some point during the quarter. A desk case review is conducted via the electronic Link record

6. If applicable, what is the universe and sample size?

The Universe is based upon the number of Juan F. Children in care. This includes children under the age of 18 and who do not have a legal status of statutory parent. During the 3rd quarter of 2015, the Universe consisted of 2,743 children in care, a sample of 1,383 and 117 who required a case review. These numbers change every quarter.

7. What data is collected?

Data collected includes but is not limited to:

- Demographics
- Type of Placement
- Reason for separate placements of siblings

8. Where is the data housed?

The spreadsheet utilized is stored in the ORE SharePoint site.

9. What types of analyses are done?

Count analysis is completed by utilizing pivot tables in Excel.

10. How are the attending data/reports disseminated?

Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Court Monitor.

11. Are data/reports shared with staff and providers?

Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Court Monitor. Area Office staff can request further analysis from ORE.

12. How are the findings from each activity used to inform change?

The information has been used by senior management to discuss results, reporting parameters and case practice with the Plaintiffs for the Juan F. Consent Decree.

Outcome Measure 20: Achievement Measures on Discharge (AMOD)

1. What recurrent QA/QI activities are happening?

   Case reviews are conducted on all discharged youth in order to determine compliance with the Exit Outcome. This report is completed and submitted to the Office of the Court Monitor quarterly based on a calendar year.

2. What results are each activity intended to achieve?

   Full-fill the reporting requirement of the Juan F. Consent Decree and demonstrate the Department's compliance with the Exit Outcome. The standard is that at least 85% of youth, 18 and over who are discharged from the Department's care meet at least one of the 6 measures.

3. How frequently do each of the activities occur?

   The case review occurs on an ongoing basis and the reports are completed and submitted quarterly.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Case Reviews: Social Workers, Children Services Consultants, Social Work Supervisors
   Data Analysis and Report Completion: Children Services Consultant
   Report Approval and Submission to the Office of the Court Monitor: Social Work Supervisor

5. What methodologies are used for each activity?

   - Universe: In order to create the universe of cases that is reviewed, a Link report is generated on a monthly basis with the list of youth who appeared to have been discharged the previous month. Due to technical limitations, the list is not exhaustive. In order to ensure all appropriate youth are included in the case review, Area Office liaisons provide the Office for Research and Evaluation a list of the youth that have discharged form their office.
   - Case Review: A desk case review is conducted via the electronic Link record. If clarification is needed in order to determine whether any of the measures have been met, the last assigned social worker is contacted. If a response is not received, the social worker supervisor is then contacted.

6. If applicable, what is the universe and sample size?

   The universe consists of all youth, age 18 and over who were committed due to being abused/neglected/uncared for to the Department's care at the age of 18. The entire universe is included in the case review. During the 3rd quarter of 2015, the universe consisted of ninety-two youth. The universe size changes every quarter.

7. What data is collected?

   The data collection instruments includes questions regarding (but not limited to) the following areas:

- Demographics
- Education
- Employment
- Living Situation
- Mental Health
- Substance
- Abuse
- Parenting
- Service Provision
- Resources

8. Where is the data housed?

   The completed instruments are stored in the ORE SharePoint and the data is exported to Excel for data analysis purposes.

9. What types of analyses are done?

   Count analysis is completed by utilizing pivot tables in Excel.

10. How are the attending data/reports disseminated?

    Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Office of the Court Monitor.

11. Are data/reports shared with staff and providers?

    Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Court Monitor. Area Office staff can request further analysis from ORE.

12. How are the findings from each activity used to inform change?

    Findings have been used to inform the legislature of the status of discharged youth.

Outcome Measure 21: Discharge of Children Diagnosed with a Mental Illness or Mental Retardation

1. What recurrent QA/QI activities are happening?

   Case reviews are conducted on all discharged youth in order to determine compliance with the Exit Outcome. This report is completed and submitted to the Office of the Court Monitor quarterly based on a calendar year.

2. What results are each activity intended to achieve?
   Full-fill the reporting requirement of the Juan F. Consent Decree.

3. How frequently do each of the activities occur?

   The case review occurs on an ongoing basis and the reports are completed and submitted quarterly.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

Case Reviews: Social Workers, Children Services Consultants, Social Work Supervisors
Data Analysis and Report Completion: Children Services Consultant
Report Approval and Submission to the Office of the Court Monitor: Social Work Supervisor

5. What methodologies are used for each activity?

Universe: In order to create the universe of cases that is reviewed, a Link report is generated on a monthly basis with the list of youth who appeared to have been discharged the previous month. Due to technical limitations, the list is not exhaustive. In order to ensure all appropriate youth are included in the case review, Area Office liaisons provide the Office for Research and Evaluation a list of the youth that have discharged form their office.

Case Review: A desk case review is conducted via the electronic Link record to determine if a youth requiring a DHMAS/DDS referral. If there isn't clear evidence in the Link electronic record Tom Ranallo in the Behavioral Health department is contacted and he corresponds with the Area Office Area Resource Group (ARG) to determine the whether or not the youth actually required a referral, if one was completed and the status. That information is then considered in the determination of the outcome being met.

6. If applicable, what is the universe and sample size?

The universe consists of all youth, age 18 and over who were committed due to being abused/neglected/uncared for to the Department's care at the age of 18. The sample consists of those discharged youth who required a DHMAS/DDS referral. During the 3rd Quarter 2015 the universe consisted of ninety-two youth and the sample consisted of fifty-four youth. The universe and sample size change every quarter.

7. What data is collected?

The data collection instruments includes questions regarding (but not limited to) the following areas:

- Demographics
- Education
- Employment
- Living Situation
- Mental Health
- Substance
- Abuse
- Parenting
- Service Provision
- Resources
- DHMAS/DDS referral result

8. Where is the data housed?

The completed instruments are stored in the ORE SharePoint and the data in exported to Excel for data analysis purposes.

9. What types of analyses are done?

Count analysis is completed by utilizing pivot tables in Excel.

10. How are the attending data/reports disseminated?

    Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Court Monitor.

11. Are data/reports shared with staff and providers?

    Completed reports are uploaded onto the ORE SharePoint site which is then available to all staff and the Court Monitor. Area Office staff can request further analysis from ORE.

12. How are the findings from each activity used to inform change?

    Findings have been used to inform the legislature of the status of discharged youth.

Child Visitation with Siblings and Parents

In response to the Section 17a-10a1 of the Connecticut General Statutes was amended by Public Act 12-71 which became effective October 1, 2014, which affirms the need for child and parent visitation the Department of Children and Families conducted a study. The DCF Office for Research and Evaluation, in collaboration with Regional Quality Improvement managers and other qualified reviewers, conducted a study of 154 target children who were under the care and custody of the Commissioner of DCF at some point between October 1, 2014 and June 30, 2015. Each child's visitation with their parents, and each of their identified siblings were evaluated. Compliance with the statute was operationalized at the target child and sibling level, resulting in measurement for 278 sibling pairs and 154 children with their parents.

1. What recurrent QA/QI activities are happening?

   Currently there are discussions regarding the case review process for the upcoming reporting year.

2. What results are each activity intended to achieve?

   Demonstrate the Department's compliance with the legislative law and highlight case practice regarding visitation of children in care with their parents and siblings.

3. How frequently do each of the activities occur?

   Case reviews will occur on an ongoing basis. Reporting occurs once a year. The report is due to the legislature on October 1st of every year.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Case review: Staff from the Office for Research and Evaluation and Quality Improvement/Assurance staff from the Area Office.

5. What methodologies are used for each activity?

   Case review: The electronic Link case record is reviewed as well as interviewing the assigned social worker.

6. If applicable, what is the universe and sample size?

The Universe and Sample will be determined by the number of children in care at the time that the sample is pulled. During the previous report, the universe was all children in care and the sample consisted of children who were in care who had siblings.

7. What data is collected?

Data that was collected during the previous report included:

- Demographics
- Visitation frequency of children in care with siblings
- Visitation frequency of children in care with parents

8. Where is the data housed?

The instrument was created and completed in ACCESS and the data was exported to excel. The data results and final report are stored in the ORE SharePoint and available to DCF staff.

9. What types of analyses are done?

Count analysis was completed utilizing Excel pivot tables.

10. How are the attending data/reports disseminated?

The data and report or available to DCF staff in the ORE SharePoint page. The final report was also distributed to the Area Office Management and all review participants.

11. Are data/reports shared with staff and providers?

The data and report are available to DCF staff in the ORE SharePoint page. The final report was also distributed to the Area Office Management and all review participants.

12. How are the findings from each activity used to inform change?

The findings will inform case practice regarding the barriers and recommendations to ensuring that children in care visit with their siblings and parents.

Emergency Safety Intervention (ESI)

ESI Database

1. What recurrent QA/QI activities are happening?

ORE staff maintains the accuracy of the reporting through regular screening for erroneous LINK identifiers and review of any ESI reports involving prone restraint or serious injury to a child.

2. What results are each activity intended to achieve?

Maintain an accurate and up to date record of the use of restraint and seclusion in facilities contracted, funded or operated by DCF and provide specialized notification regarding specific event conditions (use of prohibited techniques, injuries, etc.)

3. How frequently do each of the activities occur?

   Event reporting within 1 business day via web; daily updating of data available to ORE users. A LINK error check is done weekly at a minimum, other screening is triggered through automated messaging as reports come in

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Provider staff submit reports; ORE staff maintain data quality.

5. What methodologies are used for each activity?

   Web based data collection; Access and Excel used for reporting.

6. If applicable, what is the universe and sample size?

   All DCF operated, funded or contracted facilities providing direct care to children and youth are required to report into this system. For in CT facilities, child specific reporting is required for all children in care; for out of state facilities, child specific reporting is limited to CT children. For such facilities, aggregated restraint and seclusion data reporting is also required.

7. What data is collected?

   Over 100 data elements that describe the circumstances, justification, implementation and outcome of the use of restraint or seclusion.

8. Where is the data housed?

   Access database on a DOIT hosted Server

9. What types of analyses are done?

   Various reports are available as requested.

10. How are the attending data/reports disseminated?

    The ESI Viewer/Report is available to ORE staff via the ORE shared drive.

11. Are data/reports shared with staff and providers?

    Notification of reports involving prone restraints or serious injuries are automatically shared with selected DCF staff. All providers have access to their data through the web portal. No other data reports are shared at this time

DCF Recurrent and Developing QA/QI Activities

12. How are the findings from each activity used to inform change?

    To be determined

ESI Data Access: DCF Facilities

1. l
   Provide DCF facilities access to their ESI data for facility and client management

2. How frequently do each of the activities occur?

   Ongoing

3. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   ORE CSC provides technical assistance with accessing data and provider staff run the embedded reports as they need them. ORE clerical and Risk Management CSC's and managers perform data accuracy functions.

4. What methodologies are used for each activity?

   Web based data collection; Access and Excel reporting

5. If applicable, what is the universe and sample size?

   All residents of the DCF operated facilities

6. What data is collected?

   All ESI data plus unit assignment and episode of care information is collected in the ESI database. Name, placement dates and client demographic information is collected by the provider in an Excel file

7. Where is the data housed?

   ESI data is downloaded from the DOIT hosted Server and combined with client identifying and demographic information in an Excel file saved on the provider server

8. What types of analyses are done?

   This is determined by the provider

9. How are the attending data/reports disseminated?

   This is determined by the provider

10. Are data/reports shared with staff and providers?

Notifications of reports involving prone restraints or serious injuries are automatically shared with selected DCF staff. All providers have access to their data through the web portal. No other data reports are shared at this time.

11. How are the findings from each activity used to inform change?

To be determined

Child Abuse Practitioner CARELINE and Provider Data Collection and Reporting

1. What recurrent QA/QI activities are happening?

Maintenance of the data collection file as requested

2. What results are each activity intended to achieve?

Provide a record of DCF contracted services pending PIE development

3. How frequently do each of the activities occur?

As requested

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

Contractor Staff and DCF PDOC's; ORE CES will aggregate data initially

5. What methodologies are used for each activity?

Contractor/CARELINE discussions/results are documented in a spreadsheet and email notifications of the need for follow-up are automated

6. If applicable, what is the universe and sample size?

ALL Careline consultations with the Child Abuse Practitioners

7. What data is collected?

Client and family identifying information, event information, details regarding the allegation, recommendations of the medical practitioner and decision impact information

8. Where is the data housed?

Each provider has an Excel data file for collecting their information; DCF Careline has a data file with their information; Initially, combined data will be maintained in a Master file on the ORE shared drive; eventually maintained by the PDOC's in accordance with Contract Management requirements

9. What types of analyses are done?

   To be determined; anticipate PDOC review of operations for Contract Management; Supports RBA Report Cards

10. How are the attending data/reports disseminated?

    To be determined

11. Are data/reports shared with staff and providers?

    To be determined

12. How are the findings from each activity used to inform change?

    To be determined

Intimate Partner Violence Services (IPV)

1. What recurrent QA/QI activities are happening?

   IPV-FAIR (Intimate Partner Violence Services - Family Assessment Intervention Response) Data Collection and Reporting

   Tool developed and in use-awaiting reporting requirements

2. What results are each activity intended to achieve?

   Provide a record of DCF contracted services pending PIE development.

3. How frequently do each of the activities occur?

   Monthly

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Contractor Staff and DCF PDOC's; ORE CSC will aggregate data initially.

5. What methodologies are used for each activity?

   Client episode of care information is completed upon discharge and forwarded to the PDOC for aggregating and analysis

6. If applicable, what is the universe and sample size?

   N/A

7. What data is collected?

   PDOC designated data elements to assess the quantity and outcome of the services provided per episode of care.

8. Where is the data housed?

   Initially this will be maintained in a file on the ORE shared drive; eventually maintained by the PDOC's in accordance with Contract Management requirements

9. What types of analyses are done?

   PDOC review of operations for Contract Management; Supports RBA Report Cards
   a. l with information necessary to assess the quality of their data, and of their service delivery and outcomes.
   b. There are often questions on the use and interpretation of results from existing reports, as well as suggestions or requests for enhancements to existing reports that require response from ORE and/or KJMB.
   c. There are currently about 39 unique program models that use the PIE system, of over 80 for which DCF contracts with private providers. It is the agency's intention that all programs use this system to report data and outcomes, so ORE regularly works to help develop custom data collection models for new programs.

2. How frequently do each of the activities occur?

   a. New reports are supposed to be developed during each six-month period, with implementation occurring in April and October each year. Budget constraints have drastically curtailed this work in recent years.
   b. On an ongoing basis
   c. New programs and enhancements to the database are supposed to be developed during each six-month period, with implementation occurring in January and July each year. Budget constraints have drastically curtailed this work in recent years.

3. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   a. ORE Program Manager, PDOCs and KJMB in collaboration with providers.
   b. ORE Program Manager and KJMB
   c. ORE Program Manager, PDOCs and KJMB in collaboration with providers.

5. What methodologies are used for each activity?

6. If applicable, what is the universe and sample size?

   N/A

7. What data is collected?

See PIE Master Data Element List on the PIE Help Docs & Forms page

8. Where is the data housed?

   On external servers hosted by KJMB

9. What types of analyses are done?

   Frequency distributions and cross-tabulations?

10. How are the attending data/reports disseminated?

    Electronically by accessing the system, and by PDOCs during regular meetings with provider groups.

11. Are data/reports shared with staff and providers?

    Yes.

12. How are the findings from each activity used to inform change?

    PDOCs and provider management teams utilize the information to inform practice and resource allocation decisions. They use the information to ensure that there is fidelity to each program's service model, that data is entered in a timely, complete and accurate manner, and that the clients are receiving the benefits intended.

Office for Research and Evaluation (ORE) Reports and Dashboards

1. What recurrent QA/QI activities are happening?

   ORE shares responsibility with the IT Reporting Team for designing and overseeing development and maintenance of automated reports requested by CO and Regional Management teams for use in their ongoing QA/QI activities.

2. What results are each activity intended to achieve?

   The creation and maintenance of accurate and useful information that informs case practice and management decision-making in a timely and efficient manner.

3. How frequently do each of the activities occur?

   Ongoing

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   ORE Program Manager, 2 ORE SWS and 1 ORE CSC, IT Manager and 2 FT Systems Analysts

5. What methodologies are used for each activity?

   Business analysis

6. If applicable, what is the universe and sample size? Any/all DCF database systems.

7. What data is collected? N/A

8. Where is the data housed?

   DCF SQL Server Databases and/or the CT Open Data Portal?

9. What types of analyses are done?

   Automated production of detail and aggregate reports

10. How are the attending data/reports disseminated?

    Reports are posted on our internal SharePoint site(s), and new reports are shared with SAM and relevant COPs, especially the QIC, as they are built. Other reports are posted on the CT Open Data Portal for use by stakeholders external to DCF.

11. Are data/reports shared with staff and providers?

    Yes

12. How are the findings from each activity used to inform change?

    CO and Regional/Office managers utilize the reports to ensure that DCF staff are delivering quality service, to better understand our served populations, and make informed decisions concerning systems/practice initiatives, quality assurance and improvement activities. External stakeholders use them as the basis for seeking grants, and for making local decisions that impact our shared populations.

Results-Oriented Management (ROM) System

DCF has contracted with the University of Kansas to provide updates and maintenance to the ROM automated reporting system. The ROM system provides reports for 11 of the 22 Juan F. Exit Plan outcome measures, as well as many other informational and better-formulated quality improvement indicators.

1. What recurrent QA/QI activities are happening?

   ORE is responsible for overseeing development and maintenance of the ROM system, and our IT Reporting Team handles local database and website implementation tasks. The team has been focused on implementing a new version of the system, so ongoing testing of new reports has been occurring since 2014, with implementation likely in early 2016.

2. What results are each activity intended to achieve?

   The creation and maintenance of accurate and useful information that informs case practice and management decision-making in a timely and efficient manner.

3. How frequently do each of the activities occur?

   Ongoing

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   ORE Program Manager, 1 ORE SWS, IT Manager and 2 FT Systems Analysts

5. What methodologies are used for each activity?

   Business analysis

6. If applicable, what is the universe and sample size?

   A subset of LINK data related to Differential Response System and Children-in-Placement casework.

7. What data is collected?

   Website usage data is collected by the database.

8. Where is the data housed?

   DCF SQL Server Databases

9. What types of analyses are done? Automated production of detail and aggregate reports

10. How are the attending data/reports disseminated?

    The system is available to all DCF users through their internet browsers. Quarterly results for Exit Plan reports are also archived on our Positive Outcomes for Children SharePoint site, and the DCF Court Monitor produces regular reports (previously quarterly, now twice-yearly) summarizing and interpreting the results for the federal court and plaintiffs. These reports are posted on both internal and public-facing websites.

11. Are data/reports shared with staff and providers?

    Yes

12. How are the findings from each activity used to inform change?

    Frontline staff use pro-active views of the reports as reminders of work that needs to be done and/or documented in LINK, and management uses them to report out on agency performance and inform systems/practice change as needed.

Risk Management (RM) Child Fatality Reporting

1. What *recurrent* QA/QI activities are happening?

   Production of the monthly ***Child Fatality report/tracker***.

2. What results are each activity intended to achieve?

The goal of distributing this report is to inform the Area Offices regarding information that is required for submission to RM for tracking of the Child Fatality data points, request data updates to RM and to provide the Area Offices with Child Fatality cumulative data to inform their direct practice.

3. How frequently do each of the activities occur?

While a summary message regarding unresolved fatality reports and a link to the Child Fatality report is automatically distributed on the 10th of each month, the data in the report is updated daily based on information submitted to RM from the Area Offices and based on information gleaned from case record review by RM staff.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

The ORE RM staff (CSCs and PM) are responsible for updating the RM/Critical Incident ACCESS database and Area Office response tracking Excel file in a timely and accurate manner. A separate Excel file combines data from these files to update the Child Fatality report daily. Automated E-Mail creation for specific fatality incidents and automated summary reporting are completed using the Excel files.

5. What methodologies are used for each activity?

RM identifies all child fatality reports in the Child Fatality dataset that need to be tracked as potential child maltreatment deaths. An Excel file is ~~to be~~ utilized to inform the Area Offices about missing data items in the RM child fatality file and to track the receipt of new information. This Monthly Child Fatality report tracker replaces the need for the RM staff to continue to follow-up on each individual file through e-mails to individual Area Office staff requesting specific data in order to complete the RM file. A complete RM file is essential to making decisions about whether or not a child fatality is the result of maltreatment. (Ex. Medical Examiner's report findings can help to conclude that an "Unknown" Child Fatality is actually the result of a child's exposure to her parent's illegal drugs that were found during a toxicology test during the autopsy).

The RM CSC conducts case record review of LINK narrative and investigations/FAR documentation as well as follow-up direct contact with Area Office social work staff to obtain specific data to complete the information in the RM Child Fatality record. This often requires tracking of the individual child fatality through the end of the Area Office documentation of the investigation of the circumstances surrounding the child fatality, such as the review of police reports, newspaper articles and judicial public information.

6. If applicable, what is the universe and sample size?

The universe includes all Child Fatalities that are reported to Risk Management. Response tracking began with all fatalities reported since August 2014.

7. What data is collected?

The data collected in the RM/Critical Incident ACCESS database is comprehensive and includes both factual descriptive data as well as narrative data relating to a full description of the child fatality incident. The data elements that are included in the Monthly Child Fatality report tracker are a sub-set of the full dataset and include: Child Name, Date of Birth, Age at Death, Gender, LINK Case ID, Area Office, Incident Date and RM

Update Status (complete or Incomplete). The final column of the Monthly Child Fatality report lists the information required to be submitted to RM in order to complete the RM record.

Additionally, the data presented in the Monthly Child Fatality report tracker is organized by Regions and Area Offices to indicate the total number of Child Fatalities that have occurred beginning with January 1, 2015, how many occurred the Previous Month (to the reporting month), how many occurred in the current month, how many Child Fatality records require updates to RM, how many records are complete, and the number of days that the oldest record is overdue. This provides the Area Offices with information in a format to assist them with prioritizing their responses to RM without receiving multiple individual e-mail prompts from RM staff.

An outstanding issue that has been identified in reviewing the incomplete Child Fatality database records is the high number of records that remain open for months awaiting Medical Examiner (ME) findings following autopsies. This information is essential in determining whether a Child Fatality is a result of maltreatment. RM is working with Dr. Michael Schultz in the Special Review Unit to develop a formal and organized system to receive regular feedback from the Medical Examiners' office regarding RM incomplete records. It has been proposed that the RM PM be the central liaison between the Medical Examiner's office and DCF in order to receive and document the ME findings in the RM database and simultaneously distribute this information to the appropriate Area Office designee. The goal is to develop an efficient process to facilitate easy communication between the Medical Examiners' office and DCF.

8. Where is the data housed?

The Monthly Child Fatality report is an Excel file ~~located in a report format that is~~ posted daily on the Risk Management SharePoint site. This report is populated by data that resides in the RM/Critical Incident ACCESS database (tracking both Critical Incidents and Significant Events) and the Excel response tracking file.

9. What types of analyses are done?

Accurate Child Fatality data is available to respond to numerous requests for Ad-Hoc reporting. The RM Monthly Child Fatality report tracker was developed to automate the process of obtaining complete and accurate data from the Area Offices to enter into the RM/Critical Event ACCESS database. The complete files are then utilized to evaluate whether or not maltreatment played a role in the death of the child. The comprehensive dataset allows for trend analysis over time and supports an understanding of the common risk factors that appear to be contributing to the possibility of a child fatality.

RM also captures data regarding other Critical Incidents, such as broken bones/bruising in a child less than 6 years old or any serious injury that could lead to a fatality that are as a result of abuse or neglect. These cases are also followed over time by RM to determine the results of the inquiry into the incident and whether or not the incident progresses on to a fatality or to additional Critical Incidents. Further expansion of the Critical Incident report trackers to include broken bones/bruises under 6 years old and serious injuries is a priority within the RM data and report development agenda.

10. How are the attending data/reports disseminated?

A notification to the Area Office Director summarizing information due and linking them to the SharePoint Report folder containing the Monthly Child Fatality report is automatically distributed on the 10th of each month via e-mail.

11. Are data/reports shared with staff and providers?

The automatic distribution of the link to the Monthly Child Fatality report occurs on the 10th of each month via e-mail to each Area Office Director and Regional Quality Manager and selected DCF managers.

Ad-hoc reporting of the full data set of Child Fatality information is also regularly shared with the Office of the Child Advocate, the Court Monitor, DCF Public Relations and legislative groups as requested. At times, these reports are shared as the result of Freedom of Information requests with other interested parties.

12. How are the findings from each activity used to inform change?

The findings related to the Child Fatality database are utilized to understand the risk factors associated with Child Fatalities and to inform specific child welfare practice improvements necessary to reduce the likelihood of future Child Fatalities.

The information gathered through the RM/Critical Incident ACCESS database as it relates to Child Fatalities has been used to identify child fatality risk factors that the new RM quality intervention model is currently being implemented to address. The new model is entitled "Eckerd Rapid Safety Feedback" and involves intensive "real time" identified high-risk case review by clinical social work associates (CSWA) followed by case staffings and coaching with the area office social worker and social work supervisor. The model utilizes predictive analytics to identify the highest risk cases and then applies a nine question "real time" qualitative case review with the goal of reducing maltreatment related fatalities and serious injuries.

Special Investigations Database

The Office for Research and Evaluation oversees a database system which documents and follows referrals for a unique set of identified "eligible" program types. These program types, and when a referral is entered into the database system, are outlined in the table below.

Program Type	Accepted Referral	Not Accept Referral
After School Programs	**Credentialed:** Entered **Not Credentialed:** Entered if program concerns	**Credentialed:** Enter **Not Credentialed:** Not entered
Camps	Enter if program concerns	Not entered
DCF Facilities	Enter	Enter
DCF licensed facilities	Enter	Enter
DCF utilized (we place youth here) facilities	Enter	Enter
DCF Contracted Therapeutic Child Care	Enter	Enter
Extended Day Treatment Providers (EDT)	Enter	Enter
Foster Care (CORE and TFC)	Enter if regulatory violations	Not entered
Hospitals (other than Solnit South)	Enter if program concerns	Not entered
Schools - Public/Private	Enter if program concerns	Not entered
Transportation Companies	**Credentialed:** Enter	**Credentialed:** Enter

	Not Credentialed: Enter if program concerns	**Not Credentialed:** Not entered

The SIU database captures specific points of time in the life of a referral and documents program responses for investigations that identify program concerns or regulatory violations. These points in time are:

1. At the receipt of the referral as outlined in the table above.
2. At the conclusion of the Special Investigation Unit investigation and promulgation of the corresponding report in cases where there is a program concern(s) or regulatory violation(s).
3. When, if indicated, DCF requests a Structured Development Plan (SDP) to address program concern(s) or regulatory violation(s).
4. Upon receipt of a SDP from a program in response to item 3 above.
5. During follow-up when indicated.

1. What recurrent QA/QI activities are happening?

   The SIU database work is in itself a recurrent QA/QI activity in that the database is an ongoing task completed as related to any for an eligible program type. However, each referral is a stand-alone item and does not have a recurrent quality to the work for that respective referral within ORE. Dependent on the outcome of the referral, other entities within DCF may perform recurrent QA/QI work as deemed necessary, e.g. DCF Licensing may initiate a recurrent QA/QI activity related to the outcome of the investigation of a referral where regulatory violations were identified.

2. What results are each activity intended to achieve?

   Each step of the activity is intended to achieve the following:

   1. At receipt of the referral -
      - Document key components of the referral information and the complete narrative of the allegation.
   2. At the conclusion of the Special Investigation Unit investigation indicating a program concern(s) or regulatory violation(s) -
      - Document the results of the investigation when there are specific concern(s) or violations(s).
   3. When, if indicated, DCF requests a Structured Development Plan (SDP) to address program concerns or regulatory violations.
      - Document the request by DCF for a SDP
   4. Upon receipt of a SDP from a program in response to item 3 above.
      - Document the receipt of the SDP from the respective program and the determination that the SDP addresses the identified program concern(s) or violation(s).
   5. During follow-up when indicated.
      - Document follow-up when indicated.

   Ultimately, these steps serve to support a database system for DCF use related to QA/Qi activities pertaining to individual programs and/or program types.

3. How frequently do each of the activities occur?

   Each of these activities occurs for a respective referral upon receipt of the referral through the completion of the applicable steps for the referral.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   The database is maintained by staff in the positions of Children Services Consultants, with a chain of command of a Social Work Supervisor, Program Manager, and Program Director. Steps 3 and 4 include the use of electronic communication which brings in the following persons who, dependent upon the situation, may become involved in the matter.

   i. The respective program's Executive Director
   ii. The respective program's Assistant Director
   iii. DCF Licensing Unit Manager
   iv. DCF Risk Management Unit Manager
   v. DCF Office for Children and Youth in Placement Manager
   vi. DCF Special Investigations Unit Manager
   vii. DCF Office for Research and Evaluation Manager **if** there is an egregious program concern(s) or violation(s)
   viii. DCF Program Lead
   ix. DCF Systems Development Manager assigned to the office serving the (alleged) victim
   x. DCF Systems Clinical Manager assigned to the office serving the (alleged) victim
   xi. DCF QA/AI Manager assigned to the office serving the (alleged) victim

5. What methodologies are used for each activity?

   1. At receipt of the referral -
      a. Assigned staff enter a referral into the database based on the table included earlier in this section.
   2. At the conclusion of the Special Investigation Unit investigation indicating a program concern(s) or regulatory violation(s) -
      a. Assigned staff enter the results of the investigation into the database.
   3. When, if indicated, DCF requests a Structured Development Plan (SDP) to address program concerns or regulatory violations.
      a. Assigned staff issue a letter to the program indicating the outcome of the investigation and the program concern(s) or violation(s). The letter, which is accompanied by a copy of the Special Investigations Unit report, is emailed to the program and the entities noted in the list for Question 4 above. The letter requests a response from the respective program within 14 calendar days.
      b. Assigned staff track and follow up on requests that do not yield a response within 14 calendar days. If no response is received within 28 calendar days, assigned staff raise the matter to their direct supervisor to address.
   4. Document the request by DCF for a SDP
      a. Assigned staff document the issuance of the above letter from Step 3
   5. Upon receipt of a SDP from a program in response to item 3 above.
      a. Assigned staff review the response to determine if it addresses the(all) identified concern(s) or violation(s). In the event that the response does not address the entirety of DCF's SDP request, staff follow up with the program, including the entities indicated in the list for Question 4.

   b. Assigned staff disseminate the response to the entities noted in the list for Question 4.
   c. In the event that an entity from the list for Question 4 determines the response is not satisfactory, the assigned staff may be requested to follow up with the respective program.
6. Document the receipt of the SDP from the respective program and the determination that the SDP addresses the identified program concern(s) or violation(s).
   a. Assigned staff documents the SDP response in the SIU Database.
   b. Assigned staff documents the SDP response in DCF LINK as a narrative entry in the Provider's electronic record.
7. During follow-up when indicated.
   a. Assigned staff documents follow-up needs and/or results when indicated.

6. If applicable, what is the universe and sample size?

   There universe is that of all referrals which are eligible for inclusion in the SIU Database as per the table at the onset of this section.

7. What data is collected?

   Numerous data points are collected related Careline report, including: alleged victim, alleged perpetrator, allegations, etc., etcetera. Other data is collected related to SDPs and follow-up when indicated.

8. Where is the data housed?

   Data is house in DCF SIU Database stored on ORE drive.

9. What types of analyses are done?

   At this time, there are no analyses done.

10. How are the attending data/reports disseminated?

    At this time, there are no data/reports disseminated.

11. Are data/reports shared with staff and providers?

    The database is available internally to a set of staff that have been identified as working within the database environment or requiring access to the database, e.g. ORE management. At this time, there are no reports issued.

12. How are the findings from each activity used to inform change?

    The findings from the investigation are used by the provider to address the issue(s) and develop a SDP that is acceptable to DCF. On an individual referral basis, investigation findings and SDP responses may be used by other entities within DCF to inform change. Narrative entries in LINK for SDP responses are used by the Licensing and the Special Investigations Units during the course of their work when applicable.

Office for Research and Evaluation Quality Assurance Summary: Developing Activities

There are quality assurance activities in development within the Office for Research and Evaluation, ORE. Each of these activities is indicated below, in a stand-alone section.

Risk Management (RM) Significant Event and Critical Incident Reporting

Child Arrests

1. What recurrent QA/QI activities are happening?

   RM recurrent qualitative activity that is currently being developed is reporting regarding ***Child Specific Arrests***. This is targeted for production in February/March of 2016.

2. What results are each activity intended to achieve?

   The Arrest reports are important for evaluating Disproportionate Minority Contact, evaluating the quality of treatment interventions of Congregate Care treatment providers and the evaluation of juvenile justice interventions on subsequent arrests of previously arrested or incarcerated youth.

3. How frequently do each of the activities occur?

   The frequency of the report production is to be determined, but will be at least quarterly reports posted in an area that is accessible to all DCF staff. It is anticipated that these reports will also be posted in an area accessible for public review based on requests from a number of non-profit advocacy groups and an effort on the part of the Department to be transparent.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   The ORE RM staff (CSCs and PM) are responsible for updating the RM/Significant Event ACCESS database in a timely and accurate manner that will feed Arrest reporting. Training will need to occur in the provider community, with all foster parents and with area office social work staff to encourage accurate and timely reporting of child specific arrests to RM and to develop an understanding of the importance and usefulness of gathering this information.

5. What methodologies are used for each activity?

   Methodologies related to child specific arrest reporting will again be based on a comprehensive dataset that is inclusive of all data points identified during the development phase of arrest reporting as essential in answering critical questions that related to the child specific arrests. For example, the current database

captures the incident date, a description of the incident and the youth's current placement. During questions regarding DMC, advocacy groups working with the Department requested to review a subset of youth whose hometown is Hartford. RM doesn't currently capture that data element and needs to build "youth hometown" into the data elements.

Once all of the data elements that are required have been identified, then the report methodologies can be explored. Currently, "number of arrests per client days" and graphs of this information is available on a limited basis. It appears that this type of report would be extremely helpful to have available as a part of the posting of the Arrest reporting beyond simply child specific arrests. Aggregate reporting is also very useful. RM has recently expanded the ability to capture the specific types of arrests, for example "Assault 2", but unfortunately often all that is reported to RM is that the youth was arrested without information regarding the specific charge. It is hoped that through outreach by RM to the Area Offices, Congregate Care, Foster care and others we can increase the timeliness and accuracy of Arrest reporting.

6. If applicable, what is the universe and sample size?

The universe includes all child specific Arrests that are reported to Risk Management.

7. What data is collected?

A comprehensive descriptive list of data, including but not limited to: youth name, age, birth date, gender, race, ethnicity, legal status, arrest date and a descriptive narrative account of the arrest incidence. Additional data elements are being identified as a part of the Arrest reporting development workgroup.

8. Where is the data housed?

The Arrest data is collected from a variety of sources (Area Office social work staff, Congregate Care Providers, Foster Parents (Core and Therapeutic), detention liaisons, DCF SCJM liaisons) and reported to Risk Management for data entry into the RM/Significant Events ACCESS database. The reports that are created (to be determined) will be posted on a site that is accessible to all DCF staff.

9. What types of analyses are done?

The goal of the analysis of child specific Arrest reporting is to come to a better understanding of the factors that contribute to youth arrests. It is expected that this will occur through both qualitative and quantitative study of the Arrest data by RM and Area Office Quality staff, once the data includes the necessary data elements that are comprehensive and accurate.

Ad-Hoc reporting was found to be lacking certain essential data points, resulting in the current organized attempt to develop a regular reporting mechanism that will be able to address data points that are important in answering the key questions. This is the development work that is currently underway.

10. How are the attending data/reports disseminated?

The types of Arrest reports as well as dissemination methods are yet to be determined. It is anticipated that arrest reports, at a minimum, will be posted on a quarterly basis in a DCF site accessible to staff and the public.

11. Are data/reports shared with staff and providers?

Data and reports that are currently in development will be shared with staff and providers.

12. How are the findings from each activity used to inform change?

It has been initially identified that training is required in order to inform/remind all social work staff of the importance of child specific Arrest reporting, including a revision of the report form to include all essential data points.

Arrest reporting has been utilized to impact conversations regarding therapeutic interventions vs. police calls/arrests of youth who are receiving treatment in placement. Recent goals of the work of the Office of Children and Youth in Placement has been to increase the abilities of Congregate Care providers to de-escalate behaviors and intervene in a trauma-informed manner rather than contacting the Police to intervene and ultimately further traumatize the youth. Additional data points that describe exactly where arrests are taking place (at home on a pass, in the community on a pass or activity or in the congregate care facility) will help to inform the interventions with the Congregate Care providers to effect change.

DCF Recurrent and Developing QA/QI Activities

Special Critical Incident

1. What recurrent QA/QI activities are happening?

   Special Critical Incident Tracking

2. What results are each activity intended to achieve?

   Maintain an accurate and complete record of certain identified Critical Incidents reported to DCF

3. How frequently do each of the activities occur?

   Daily updating

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   CARELINE staff provide initial information, AO directors or designees provide case information; RM CSC reviews submissions for completeness and enters data into database

5. What methodologies are used for each activity?

   When DCF RM receives notice of an incident, it is entered into the SE/CI Access database. An Excel file will extract all new reports meeting certain criteria and saves them to the tracking tool for collection of required information. The Excel file will have automation for email notifications to Area Office directors

6. If applicable, what is the universe and sample size?

   N/A

7. What data is collected?

   Client and family identifying information; event description, and items required to close the record

8. Where is the data housed?

   Risk Management Access Database; future Excel tracking tool

9. What types of analyses are done?

   To be determined

10. How are the attending data/reports disseminated?

    To be determined

11. Are data/reports shared with staff and providers?

    To be determined

12. How are the findings from each activity used to inform change?

To be determined

Eckerd Rapid Safety Feedback

Eckerd Rapid Safety Feedback (ERSF) is a business intelligent approach to child welfare quality.

1. What recurrent QA/QI activities are happening?

   ERSF is being implemented in Connecticut DCF to provide a preventative and proactive quality improvement intervention in a specific high risk sample of child welfare cases. The goal of this intervention is to reduce and/or eliminate child maltreatment fatalities and serious injuries that occur in families known to the Department. The sample that has been identified for the ERSF intervention will be children ages newborn to three in families with open in-home services cases as well as any maltreatment report that is accepted for investigation or assessment regarding a family that has a history of three or more child welfare investigations or assessments. The high risk sample will be identified in collaboration with Mindshare, our child welfare technology partner, utilizing predictive analytics that will identify cases to be mined in real time for the common risk factors identified with cases that have a high risk of child maltreatment related tragedy or death.

2. What results are each activity intended to achieve?

   The Eckerd Rapid Safety Feedback intervention is intended to reduce and/or eliminate child maltreatment related fatalities and serious injuries that occur in families known to the Department. It is also expected that the Department will observe an improvement in the effectiveness of case specific safety planning, in the quality of engagement between social workers and children/families, in the effectiveness of supervision and in the quality and frequency of sharing critical case information with various providers.

3. How frequently do each of the activities occur?

   The independent file reviews of the high risk cases and subsequent case staffing will occur on a daily basis, in collaboration with the Area Offices. A staffing is scheduled with the social worker and supervisor only if safety concerns are identified by the ERSF reviewer that have not been addressed. More specifics of this process will be identified following the formal ERSF training conducted by the Eckerd staff.

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   The ERSF team is comprised of two ORE Program Managers and four clinical social work associates who will be responsible for the day to day functioning of the model. Additionally, the ORE Director and additional Program Manager are consulting in the development and implementation of ERSF, including the data identification and sharing with Mindshare. The IT division has been involved in the process of sharing data with Mindshare and a data sharing agreement has been developed and signed. The Chief of Quality and Planning has been actively involved in the development and implementation of the project within the Department.

5. What methodologies are used for each activity?

The methodology utilized for the case specific related activity is qualitative case review followed by mentoring and coaching case management. The methodology utilized to identify the high risk cases is predictive analytics. These activities will be more fully explained and understood following the formal training that will be provided by the Eckerd staff.

6. If applicable, what is the universe and sample size?

The universe includes all open in-home cases with a child age newborn to three years of age as well as all investigations or family assessments regarding families with a history of three or more investigations or family assessments. It has been acknowledged that the Department's capacity to review all of the identified high risk cases in these categories is limited, and once the universe has been identified by Mindshare, decisions will be made regarding the actual sample size that will be included in the ERSF intervention.

7. What data is collected?

LINK case related data is provided to Mindshare to produce the real time data to be utilized to identify the high risk child welfare cases. The data that is collected as a result of the independent file review is related to child and family specific information related to risk and safety. This information is utilized in discussion with Area Office social workers and supervisors when safety related issues are identified during the ERSF intervention that have not been addressed.

8. Where is the data housed?

The data utilized to identify the high risk cases and to support the independent file review is primarily from the LINK system in collaboration with Mindshare.

9. What types of analyses are done?

Mindshare runs a system overlay software with LINK that produces real time data and agency performance dashboards. This allows cases to be mined in real time for the common risk factors identified with cases that have a high risk of child maltreatment tragedy or death.

10. How are the attending data/reports disseminated?

As ERSF is implemented, the data and reports dissemination will become evident. It is yet to be determined.

11. Are data/reports shared with staff and providers?

The data produced by Mindshare is used to identify the high risk cases that require ERSF intervention. Data or reports developed to report on the subsequent impact of ERSF in Connecticut are yet to be determined and will likely be influenced by the implementation of the Casey Family Program's sponsored evaluation of the ERSF implementation in collaboration with Eckerd of Florida and Maine.

12. How are the findings from each activity used to inform change?

The goal of this intervention is to reduce and/or eliminate child maltreatment fatalities and serious injuries that occur in Connecticut families known to the Department. It is also expected that the Department will

observe an improvement in the effectiveness of case specific safety planning, in the quality of engagement between social workers and children/families, in the effectiveness of supervision and in the quality and frequency of sharing critical case information with various providers. Reports will be developed to share the results of the intervention as the implementation of ERSF proceeds based on input from the Eckerd Team and the Eckerd Advisory Group as well as DCF Senior Management.

Case Review System (CRS)

1. What recurrent QA/QI activities are happening?

   Case Review System (CRS) for Child and Family Service Reviews (CFSR) & Administrative Case Reviews (ACR)

2. What results are each activity intended to achieve?

   Improve DCF efficiency and effectiveness in conducting Federal Child and Family Service reviews; improve the efficiency and effectiveness of the DCF Administrative Case Review process

3. How frequently do each of the activities occur?

   Under Development-will be continuous

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

5. What methodologies are used for each activity?

6. If applicable, what is the universe and sample size?

7. What data is collected?

8. Where is the data housed?

9. What types of analyses are done?

10. How are the attending data/reports disseminated?

11. Are data/reports shared with staff and providers?

12. How are the findings from each activity used to inform change?

Wilderness School

1. What recurrent QA/QI activities are happening?

   Wilderness School Data collection and reporting (data collection tool under development)

2. What results are each activity intended to achieve?

   Improving operational efficiency and creating an accurate record of Wilderness school program operations

3. How frequently do each of the activities occur?

   Under Development

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   ORE CSC is providing technical assistance. Provider staff are responsible for data entry and determining reporting needs

5. What methodologies are used for each activity?

   N/A

6. If applicable, what is the universe and sample size?

   N/A

7. What data is collected?

   Participant data, program activity data, client survey/assessment data will be collected

8. Where is the data housed?

   Currently in Excel files and the SharePoint site

9. What types of analyses are done?

   To be determined

10. How are the attending data/reports disseminated?

    To be determined

11. Are data/reports shared with staff and providers?

    To be determined

12. How are the findings from each activity used to inform change?

    To be determined

Connecticut Juvenile Training School (CJTS)

1. What recurrent QA/QI activities are happening?

   CJTS QA & Data Development workgroup

2. What results are each activity intended to achieve?

   Identify measures to track and improve outcomes for children and operational efficiencies for the facility

3. How frequently do each of the activities occur?

   Under Development

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

5. What methodologies are used for each activity?

6. If applicable, what is the universe and sample size?

   N/A

7. What data is collected?

8. Where is the data housed?

9. What types of analyses are done?

10. How are the attending data/reports disseminated?

11. Are data/reports shared with staff and providers?

12. How are the findings from each activity used to inform change?

Permanent Placement Services Program (PPSP)

1. What recurrent QA/QI activities are happening?

   PPSP Data Collection and reporting (data collection tool under development)

2. What results are each activity intended to achieve?

   Provide a record of DCF contracted services pending PIE development.

3. How frequently do each of the activities occur?

   Monthly

4. Who is responsible for carrying out each of the activities (e.g., position type(s)/level(s))?

   Contractor Staff and DCF PDOC's; ORE CSC will aggregate data initially.

5. What methodologies are used for each activity?

   Client referral and service agreement is updated as it occurs and episode of care information is completed upon discharge; data to be submitted monthly for aggregating and analysis.

6. If applicable, what is the universe and sample size?

   All clients referred to PPSP contract services

7. What data is collected?

   PDOC designated data elements to assess the quantity and outcome of the services provided per episode of care.

8. Where is the data housed?

   Initially this will be maintained in a file on the ORE shared drive; eventually maintained by the PDOC's in accordance with Contract Management requirements

9. What types of analyses are done?

   PDOC review of operations for Contract Management; Supports RBA Report Cards

10. How are the attending data/reports disseminated?

    To be determined

11. Are data/reports shared with staff and providers?

    To be determined

12. How are the findings from each activity used to inform change?

    To be determined

Region 1 Recurrent and Developing QA/QI Activities

Senior Leadership weekly meeting:
Senior leaderships meets each Thursday and reviews data on a rotating basis based on the reports listed below. Senior Leadership responds to any data trends wherein we see a decrease in performance.

Relative Checklist

- Objective of the RC is to ensure concerted efforts are being made to seek out maternal and paternal resources for placement purposes and visiting supports.
- ***Sample and frequency***: this is completed on every case prior to requesting a core foster home.

Case Plan cover sheet

- Objectives of the CP cover sheet is to ensure supervisory oversight of case plans prior to approval.
- **Sample and frequency**: this is completed for every case plan in home and out of home case plans. The PM reviews 5 cover sheets and the associated approved plan weekly to monitor compliance and efficacy of the CP cover sheet.

Court Monitor Learning Forums

- The objective of the CM learning forums is to provide a strength based approach to group supervision with a focus on case planning OM3 and 15. The learning forums allow the supervisors and units to look through the lens of ACR and CM in evaluating case practice.
- ***Sample and frequency:*** The learning forums are scheduled for each case reviewed by the CM in each quarter. The PM, SWS and unit all attend, the PM extends the invitation to the work group.

CQI Intake

- The purpose of the Region 1 Intake Case Review is to gain an assessment of the quality of the intake and investigation process, as well as compliance with DCF policy and practice requirements. The reviews will also be used to identify staff training needs, policy development, and system improvements. To encourage and support staff in improving skills in serving clients and in managing agency resources.
- ***Sample and frequency***: 10 Cases Region wide: 6 Bridgeport, 4 Norwalk. Type of Report (FAR, Intake)
  A random sample of cases will be selected for review. The criteria for selection will include:

    - Closed within 30 days
    - Substantiated and Unsubstantiated
    - Information is logged by QI PM and Quarterly assessments are completed to identify Case practice challenges and areas needing improvement

No Case Contact Review

- The purpose of the no contact review is to ensure concerted efforts re made to locate, identify and assess families for Intake and FAR assignments. Every time a case is designated to be closed without making contact with the family, the Office Director reviews the case in its entirety.

Critical Incident Reviews:

- A log of all critical incidents received in the region is maintained. The log identifies which cases have been substantiated and in-sub, closed/transferred, had supports did not etc. any case that has DCF HX within a year of the critical incident is reviewed in its entirety.

- The objective of the case review is to identify store this and areas needing improvement in case practice, service delivery and investigation.
- Upon the completion of each review a learning forum is held with the PM, SWS group and workers. Often, these reviews include the support of Dr. Schultz.

OPPLA Reviews:

- OPPLA reviews are held annually for every youth with an approved plan of OPPLA. The objective of the review is to ensure that permanency team meetings are being held with the purpose of identifying natural supports to youth in care.
- Additionally, OPPLA reviews are held with the office director for every case prior to identifying a goal of OPPLA. Every case with the goal of OPPLA needs prior approval from the office director.
- The objective of director approval is to ensure that concerted efforts are being made to identify relative and kin supports and also to ensure that all preferred permanency plans have been exhausted prior to the selection of OPPLA.

Education Initiatives:

- Objective of these initiatives is to ensure children in placement reach their academic potential and have their educational needs met while in DCF care.

JJ Initiatives*:*

- JJPM,OD and RRG Monthly review of all JJ youth in congregate care settings, JJMSS meeting

Provider Initiatives:

- Monthly reviews held with contracted providers. The objective is to ensure efficacy of program services and intervention.
- Contracts SWS facilitates discussion of treatment goals, progress and barriers and provides written updates to AO staff.
- Sample/frequency: Meetings are held at least month, some contracts with more intensive services are held bi-weekly.
- Information is logged and written reports are documented in the electronic file

The results of reviews and initiatives are discussed and distributed in supervision and leadership meetings. The findings are used to inform change, the data is used to assess our progress and areas needing improvement and we modify our regional strategic plan based on our findings.

Region 1 Use of QA/QI Data

OM 3

- PM weekly review of SharePoint Case Practice report
- QI PM Bi- of monthly review of No case plan/No approved plan using ACR schedule and link.

ACR PM

- Monthly review of ACRI data including: ACRI Needs assessment, CIP Well Being, Attendance Report, and overdue ACRI (backlog) for each office with report to AO staff
- Report out monthly to leadership teams; trends ANI's and strengths

Court Monitor and QI PM

- Quarterly reviews of the Court Monitor results with all assigned staff including ACR SWS/ PM and CPS SW/SWS/PM

OM 15

OA

- Weekly review of MDE's including reconciliation of Placement/ MDE Log and follow up with AO staff
- Log of all kids in care with LINK updated and not updated sent out monthly to staff

ARG RNs

- Bi-weekly review of MDE recommendations and follow up by ARG RN with staff as needed
- Weekly review of urgent MDE recommendations and follow up by ARG RN with staff as needed

OM 16 & 17

OD

- Monthly compilation of visitation statistics for AO: ROM & Link data
- Monthly and Quarterly reports on missed visits per work group unit for each AO: ROM & Link data

PM

- Bi-weekly email reminder (15th and 25th) to AO staff regarding visitation documentation in Link
- Weekly review of missing visits data specific to OM 17 following end of prior month to ensure documentation of completed visits in Link with email to AO staff
- Review of visitation plans in LINK: initial all cases subsequent 10 per month

OM 1 & 2

Intake PMs

- Weekly review of Intake and FAR Commencement and Completion reports: ROM & f
- Monthly review of overdue Intake & FAR cases with email follow up to AO staff

OM 4

QI PM

Monthly review of new placements cross referenced with Considered Removal Teamings

OM 7, 8, 9, 11

PM

- Monthly review and distribution of Adoption, TOG, Reunification and APPLA cases report: ROM and Link data (Pre- and Post-TPR Reports)
- Review and follow up with assigned staff re: projected dates for permanency
- Monthly review of permanency reports for Pre- and Post-TPR cases including No TPR Filing Date, No Permanency Goal, Permanency Barriers, etc. with email follow up to AO staff

OPPLA reviews and log

RA, OD and QI PM

- Quarterly review and audit of OPPLA cases including specific follow up regarding permanency outcomes for the OPPLA cohort.
- Annual review for every approved OPPLA

OM 18

OA

- Weekly review of OM 18 data and email follow up to AO PM and SWS

OM 19

BHPD, RA, OD, Systems Director and QI PM

- Weekly review of congregate care placement entries and discharges and email follow up to AO staff.
- Weekly identification of stalled discharges (CC, Solnit, SFIT) with scheduled follow-up meeting and planning.

OM 21

- CO pulls each youth at age 16. RRG evaluates for DDS and DMHAS eligibility.

OM 22

- Dedicated RRG staff to ensure MDE is scheduled and occur
- Will define role for follow-up and recommendations
- 2016 plan to develop MDE protocol for Region 1

CPS IN-HOME CASE REVIEWS

ODs/ PMs

- Monthly review and email distribution of CPS cases open >9 months
- Quarterly audit and report on CPS cases open >12 months with email follow up to staff

SUPERVISORY CONFERENCES

PM

- Monthly review of SWS conference documentation compliance including review of supervision agendas

TEAMING CONTINUUM REVIEW

CFT Facilitators/ QI PM

- Monthly review of **CR-CFT** meetings including audit of attendance, recommendations, removals/ placements, family arrangements, etc. and report to leadership

RACIAL JUSTICE WORKGROUP

- Monthly review and report on regional and AO RJW activity and next steps
- Bi-annual CIP clean up re: race/ ethnicity data in Link

FATHERHOOD ENGAGEMENT INITIATIVES

- Monthly FELT (Fatherhood Engagement Leadership Team) meetings

CRITICAL INCIDENTS

QI PM

- Weekly maintenance and review of C.I. Log and AO follow up
- Participation on collegial team for case reviews, interviews and practice findings on critical cases.

ADDITIONAL ACTIVITY:

SSI/ SSDI REIMBURSEMENT

- Ongoing review and completion of SSI/ SSDI initial applications and reviews and follow up with AO staff for the region

NYTD SURVEYS

- Ongoing review and completion of NHTD surveys for cohorts for the region

550/551 TITLE IV-E REIMBURSEMENT

- Ongoing review and completion of 550/551 database and log and follow up with AO staff regarding completion of forms as needed

DCF RUNAWAY DATABASE

- Weekly review and update of Runaway Database

CFSR

- Prepare the Area Offices for participation in the upcoming 2016 CFSR process

Region 2 Recurrent and Developing QA/QI Activitie

OM 3

QI CSC

- Monthly email to AO staff of Case Plan schedule for upcoming month (include Educ. Consultants, FASU and ARG)
- Weekly review of case plans for completion (5 days prior to ACR meeting) to ensure case plan is complete with email to AO staff
- Weekly case plan follow up on: documentation of ACR meeting in Link narrative, documentation of family feedback narrative, supervisor approval within 10 days of ACRI receipt or Fam. ACR meeting/ or within 25 days of ACR meeting if ACRI is not complete with email to AO staff
- Weekly attendance by QI CSC at AO and regional OSIT meetings

ACR PM

- Monthly review of ACRI data including: ACRI Needs assessment, CIP Well Being, Attendance Report, and overdue ACRI (backlog) for each office with report to AO staff

Court Monitor Liaison

- Quarterly reviews of the Court Monitor results with all assigned staff including ACR SWS/ PM and CPS SW/SWS/PM, OD, QI SWS/PM, OCM
- Weekly attendance by OCM Liaison at AO and regional OSIT meetings

QI **SWS**

- Monthly review of SDM tools completion including FSNA Assessments and Reassessments, Risk Assessments and Reassessments, Reunification Assessments and Reassessments with email to AO staff

OM 15

QI PM

- Weekly review of MDE's including reconciliation of Placement/ MDE Log and follow up with AO staff and HSR liaison as needed
- Quarterly review and update of Health Needs Met Log for AO CIP population including audit of EPSDT appointments for children and follow up on CIP with unmet needs

ARG RNs

- Bi-weekly review of MDE recommendations and follow up by ARG RN with staff as needed
- Weekly review of urgent MDE recommendations and follow up by ARG RN with staff as needed

OM 16 & 17

QI SWS

- Monthly compilation of visitation statistics for AO: ROM & Link data
- Monthly and Quarterly reports on missed visits per work group unit for each AO: ROM & Link data

- Bi-weekly email reminder to AO staff regarding visitation documentation in Link
- Weekly review of missing visits data specific to OM 17 following end of prior month to ensure documentation of completed visits in Link with email to AO staff

SECONDARY:

OM 1 & 2

Intake PMs/QI PM

- Weekly review of Intake and FAR Commencement and Completion reports: ROM & Link data
- Monthly review of overdue Intake and FAR cases with email follow up to AO staff
- Monthly audit of Intake and FAR cases, random selection of one case from each investigations unit.

OM 4

QI PM

- Maintenance and review of New Placement and Placement Changes Logs including follow up on Notification letters, LEA Notification, MDE, etc.
- Monthly review of all new placements for the month including review and stats on kin placement, audit on PM documentation, audit on MDE
- Quarterly Placement report on new placements with audit results (PM documentation, bench OTC's, kin placement rate for each AO, etc.)

QI SWS

- Bi-weekly review of new placements and review of PRS data completion with follow up email to AO staff
- Weekly review of PRS documentation for all Assessment Conference cases prior to meeting for each AO with follow up email to AO staff
    - FASU follow up on Assessment Conference cases with no resources identified per PRS documentation

OM 7, 8, 9, 11

QI PM

- Monthly review and distribution of Adoption, TOG, Reunification and APPLA cases report: ROM and Link data (Pre- and Post-TPR Reports)
- CPS PM review and follow up with assigned staff re: projected dates for permanency
- Monthly review of permanency reports for Pre- and Post-TPR cases including No TPR Filing Date, No Permanency Goal, Permanency Barriers, etc. with email follow up to AO staff

PES/ADOLESCENT SPECIALIST

- Quarterly review and audit of APPLA cases including specific follow up regarding permanency outcomes for the APPLA cohort

OM 18

QI PM

- Weekly review of OM 18 data and email follow up to AO PM and SWS

OM 19

BHPD, ARG

- Monthly review of congregate care placement entries and discharges and email follow up to AO staff regarding CIP 12 & under, and LOS over 60 days in CC
- Monthly CC Placement Reviews with FASU/ARG/CPS staff
- Weekly review of Safe Home and STAR Shelter FASU Logs and follow up with staff regarding discharge planning and Needs Met

OM 21

ARG

- Quarterly review and distribution of CIP reports to ensure that DMHAS/DDS referrals are completed
- Monthly review and consultation with ARG Liaisons regarding AO DMHAS/ DDS Referral Logs

OM 22

QI PM

- Weekly review of MDE's including reconciliation of Placement/ MDE Log and follow up with AO staff and HSR liaison as needed
- Weekly review of Link and ROM MDE data and entry of MDE data

EPOM Reporting

QI PM

- Quarterly AO/ Region report on POC progress
- Quarterly AO/ Region PPIM (Permanency Practice Improvement Measures) reports

CPS IN-HOME CASE REVIEWS

ODs/ CPS PMs/QI PM

- Monthly review and email distribution of CPS cases open >9 months
- Quarterly audit and report on CPS cases open >12 months with email follow up to staff

SUPERVISORY CONFERENCES

QI PM/QI SWS

- Monthly review of SWS conference documentation compliance including review of scheduled SC sessions in Outlook and email follow up to AO staff

TEAMING CONTINUUM REVIEW

CFT Facilitators/ CPS PMs

- Monthly review of **CR-CFT** meetings including audit of attendance, recommendations, removals/ placements, family arrangements, etc. and report to AO staff
- Monthly review of **P-CFT** meetings including audit of attendance, recommendations, planned follow up and report to AO staff

RACIAL JUSTICE WORKGROUP REVIEW

RJWG SWS

- Monthly review and report on regional and AO RJW activity and next steps
- Bi-annual CIP clean up re: race/ ethnicity data in Link

FATHERHOOD ENGAGEMENT INITIATIVES

AO FATHERHOOD LIASONS/QI CSC/AO OA

- Monthly FELT (Fatherhood Engagement Leadership Team) AO meetings
- Weekly review and follow up on DOC Pilot (Region 2) to ensure participation of incarcerated fathers in case planning/ ACR process
- Gather monthly contacts with fathers on cases transferred from intake to ongoing services and enter into log to track fatherhood engagement

CRITICAL INCIDENTS

QI PM

- Weekly maintenance and review of C.I. Log and AO follow up
- Participation on collegial team for case reviews, interviews and practice findings on critical cases including collaboration of SRU meetings for the region

ADDITIONAL REGION 2 ACTIVITY:

SSI/ SSDI REIMBURSEMENT

ADOLESCENT SPECIALIST

- Ongoing review and completion of SSI/ SSDI initial applications and reviews and follow up with AO staff for the region
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NYTD SURVEYS

ADOLESCENT SPECIALIST

- Ongoing review and completion of NYTD surveys for cohorts for the region

550/551 TITLE IV-E REIMBURSEMENT

AO OA

- Ongoing review and completion of 550/551 database and log and follow up with AO staff regarding completion of forms as needed

DCF RUNAWAY DATABASE

MILFORD OFFICE SPECIALIST

- Weekly review and update of Runaway Database for region and follow up with AO staff
- Bi-weekly reconciliation of CIP on database and report from AO staff (email follow up to AO staff)

KIDPIX REVIEW

AO OA

Weekly review and update of Kidpix Report and email follow up to AO staff

CFSR

QI PM/QI CSC

- Participation in CFSR pilot and ongoing implementation

AT A GLANCE REPORT

QI PM

- Monthly reports for each PM/SWS detailing individual unit data on case practice reports, visitation, SWS conferences, caseload utility, cases open over 9 months with no legal

REGION 3 RECURRENT and DEVELOPING QA/QI ACTIVITIES

DRS Stats

Compilation of DRS Stats. Reports are provided to Leadership, including the Regional Administrator, Office Directors and Intake Program Managers to inform them of the functioning performance of the intake operation in regard to quantity and investigation outcomes. DRS stats are completed quarterly by the QASW. Data is gathered from LINK reports (FAR Summary, Intake Summary and CPS Reports) and sorted by office, SWS and SWS. Results are documented on an excel sheet for each office along with a summary sheet for all three offices including statewide numbers and percentages. The universe is all Region 3 Completed DRS each quarter. The data that is collected is #/% of Reports accepted, Total Far/%, Total FAR transferred to CPA/%, Total intake/%, Total Intake Sub/%,Total Intake Unsub/%, Total transferred to ongoing /%, Total Sub transferred to ongoing/%, Total Unsub transferred to ongoing/%

And #/% of referred to the community partner agency. A breakdown of the data by State, Region 3, and regional Offices, SWS's and SW's is included. The DRS stats are shared with office leadership and Intake PM's via email. It is house on the Region 3 SharePoint site. DRS stats are not shard with providers. Office Directors and Intake PM utilize the data as an educational tool for staff while looking at trends for referring to CPS, sub rates, transfer rates and need for additional oversight and/or training.

Medical/Dental Logs

Monthly medical/dental logs and graphs for each office are completed by the QASW and ensure well Child medical and dental needs are being met per EPSDT standards. Data is pulled from LINK CIP Medical Visits report as close to the first day of the month as possible. QASW reviews to see which children are overdue and completes a separate log for WCC medical and another for dental. Children overdue 0-30 days (coded in white), 30-60 days (coded in Blue) and 60+ days (coded in yellow). QASW reviews narratives, medical icon, case plans and ACRIs on children to gather information related to whether an appointment has occurred, is scheduled or still needs to be scheduled and documents the information in the comments section of the log. The sample size is all children in placement for each office. The data collected includes the date of last medical, dental and MDE. The data is not housed. The analysis includes calculating percentage of children whose needs are/are not being met, in order to determine progress toward meeting their needs. Data from the logs is noted on a running stipulated agreement sheet for each year and tracked on a graph monthly. The logs are emailed to staff and progress is shared and discussed at leadership team meetings, QIT meetings and Regional Steering Team meetings.

The logs are not shared with providers, but are shared with the DCF Office QAPM, PMs, SWS and SW's. The logs serve as a tracking mechanism and a reminder to staff in regard to unmet needs stemming from recommended medical and mental health evaluation and treatment for children in placement and enables us to track progress toward meeting their needs (OM 15).

Other Specialized Needs Logs

Tracking of special medical/dental/vision/hearing/educational needs and behavioral health needs for all children in placement. Special needs logs are being completed and disseminated to staff to ensure all recommended specialized medical/dental and behavioral health needs, other than routine EPSDT, are being addressed. They are completed monthly in each office by the QASW. Unmet needs are identified and logged from MDE recommendation and MDE Follow up meetings with RRG as well as from ANIs received from ACRIs that are forwarded to QASW from ACR SWS. QASW reviews narratives, medical icon, case plans and ACRIs on children to compile information related to whether an appointment has occurred, is scheduled or still needs to be scheduled and documents the information in the comments section of log. Region 3 children in placement. The children's names, link numbers, case assignments etc. and all unmet medical and mental health evaluation and treatment recommendations for children in placement. The logs are not housed. The logs are emailed to staff and progress is shared and discussed at leadership team meetings, WIRE/QIT meetings and Regional Steering Team meetings. It is shared with staff via email, it is not shared with providers. The logs serve as a tracking mechanism and a reminder to staff in regard to unmet needs stemming from recommended medical

and mental health evaluation and treatment for children in placement and enables us to track progress toward meeting their needs (OM 15).

Considered Removal RBA's

Considered Removal RBA are completed on a quarterly basis by the Considered Removal Supervisors in each office. The universe is all children who for whom a CR meeting was held. Data includes CR meetings held pre/post removal, kin participation, percentage of children entering care for whom a CR was held and reasons why the CR was not held, meeting outcomes and 2 week and 90 follow up. Effective Q4 2015 data pertaining to outcomes by race is also being included. RBA's are uploaded to the Region 3 SharePoint site. Staff access the information via the Region 3 SharePoint site, and through reporting and discussion at QIT's and Regional Steering Team meetings. RBA's are shared with staff and regional trends are shared at Regional Advisory council meetings. Findings inform practice regarding concerning trends and promising practice regarding maintaining children with kin and engaging families. This process provides important information to CR SWS's and office leadership regarding adherence to model fidelity as well as outcomes for children.

Congregate Care Stats

Compilation of CC stats. The stats are reviewed with the purpose of having data-informed discussions around congregate care numbers by office. The data includes a breakdown of total children in congregate care by race and children in congregate care over age 13 by race. QASW completed on a monthly basis. The data is obtained from the Region 3 CIP Dashboard. QASW sorts data to reflect how many children are in the different types of congregate care by office and also provides the breakdown with and without CJTS, Medical placements and DCF Facilities. The data is then sorted by race for the all kids in CC in the region and further sorted by race for children ages 13-17 by race. The log reports the count of kids in CC by each type and percentage of total kids in CC for each office. This data is posted to the Region 3 SharePoint site monthly. The information is shared and discussed at leadership team meetings, WIRE/QIT meetings and the Regional Steering Team meetings to track our progress regarding decreasing placement of children in congregate care and decreasing disparity by race.

Discharge Planning Meetings for Children in Congregate Care and OOS Care

Each office in the Region has weekly discharge planning meetings for youth in residential, group home, STAR placements and DCF facilities (including children placed out of state). The purpose is to ensure progress toward timely discharge, identify barriers related to treatment and discharge and identify recommendations for ongoing needs of the youth and family. If barriers toward effective treatment impacting achieving timely discharges are identified with the provider follow through in order to ensure it's addressed a Priority Case Teaming is scheduled and/or the provider teleconferences in for the next scheduled review. Identification early on of children who will need a CORE of Therapeutic foster home.

For youth in STAR and PRTF the reviews are on each youth weekly, for children in residential and group home the reviews for each youth occur every 3-5 weeks. The Clinical Director, RRG staff, FASU, SW/SWS, Value Options ICM and at times the provider participates. Discharge Planning Meeting Summary format is completed for each review. Youth in residential, therapeutic group homes and PASS homes, DCF facilities and STAR placements. Each office maintains an excel log of the children reviewed, the date reviewed and the outcome of the review. There is a Discharge Planning Meeting binder kept with all meeting notes. The excel log is kept in the office S Drive and the plan is to have them posted weekly on the Region 3 Share Point site in 2016. SW and/or SWS report on progress toward discharge, discuss recommendations and identify steps needed to move youth to a more permanent setting. The CPS team (SW/SWS) receives the Discharge Planning Meeting Summary at the end of the meeting. Identify steps/activities/timeframe needed to move youth out of congregate care.

The Case Planning/Quality Improvement Workgroup

This is intended to strengthen case work by increasing staff proficiency and competency by building relationships across functions, analyzing data and trends, streamlining workload and providing support, education and guidance to staff. This meeting occurs in Norwich and Willimantic Area Offices on a monthly basis. In each office, the QASW co-chairs the workgroup with a Social Worker Supervisor. Co-chairs set the agenda and co-lead the respective

workgroups. Subjects vary by the needs of the office and are identified by the Court Monitor representative's, ACR's, Supervisor's or Social Worker's feedback. In addition to addressing specific areas of need, case plan drafts are reviewed in Willimantic, which serves as a learning tool for staff. All types of case plans are reviewed (in home, child in placement, adolescent, voluntary). Various staff attend the groups, SW Trainees, SW's, SWS's, ACR staff. The group discusses ways to improve case planning, purposeful visitation, documentation and many other aspects of the work that ties into case planning everything. Each element of the case plan is reviewed and a hard copy record of this workgroup activity is maintained. No data is collected from this log. The information is not housed. There is no analysis performed. Court Monitor's office data as well as ACR data are shared with staff in attendance.

PRS/MDE/Kidpix Logs

PRS/MDE/Kidpix logs are kept to track timely completion of MDE's and PRS entries and ensure KIDPIX are kept current. The log is completed monthly for each office by the QASW. Data is pulled from LINK reports Children in Placement First Time Entries and also compared to ROM reports for PRS. QASW reviews to see if child has updated placement resource search information entered within 6 months from the date the child enters care. QASW ensures MDE dates and/or NA codes are entered in medical icon for children entering care and reviews whether a child has a Kidpix within 90 days of entering care. No data is collected from this log, it is an added measure for tracking progress. The sample size is all children who entered care within the prior 6 months. The information is not housed. There is no analysis performed. The log is forwarded to QAPM for further distribution to office PMs, SWSs and SWs via email. The information is shared and discussed at leadership team meetings and QIT meetings to facilitate discussion around areas needing improvement and any identified barriers.

Office Quality Improvement Teams

QIT's meets monthly in each office to review performance data, identify areas in need of improvement, and carry out and monitor improvement efforts. The meetings are attended by Management, QI Staff, committee/workgroup chairs, leads and representatives. NA for Sample size, data collected, where data is housed, types of analysis used. Minutes are shared with staff (not providers) via meetings handouts, Email and/or SharePoint. There is a managerial lead identified in each office for each outcome measure who is responsible to track office performance monthly relative to the region and state as well as to track trends over time. Each lead presents at the QIT's to help to ensure that staff are informed regarding this data. The QIT's are is intended to strengthen case work by increasing staff proficiency and competency by building relationships across functions and analyzing data and trends to inform their work.

Regional Steering Team

The Regional Steering Team will help to increase Region 3's capacity to make continuous improvements to practice, which is one of the primary goals of the Department's Strategic Plan.
The RST meets Quarterly. The Regional Steering Team (RST) is comprised of representative members in terms of work scope, formal position and diversity of our staff. Chairs for the Area Office Quality Improvement Teams and/or Workgroups are also members of the Regional Steering Team, as is Court Monitor staff. The team values the parent perspective and included in the membership is the Regional Family System Manager for FAVOR who is also a member of the Regional Advisory Council. The team evaluates membership ongoing and community partnership representation on the team is a goal. The business of the Regional Steering Team is tied to the agenda of practice-oriented issues that the Regional and Area Office Quality Improvement Teams and Workgroups are taking up, and the "next steps" work identified by the Regional Steering Team can be acted upon. NA for Sample size, data collected, where data is housed, types of analysis used. Minutes are disseminated via Email and/or Region 3 SharePoint site. All staff in the region receive a quarterly email notifying them when agendas, handouts, and minutes are posted on the Region 3 Share Point site. Decisions reached at Regional Steering Team meetings are discussed at office staff meetings, Supervisor meetings, function or work set meetings and Management and Leadership Team meetings. The Area Offices each have QI workgroups and the tasks associated with case planning are coordinated to avoid duplication within the Region. Recommendations are brought forward to the RST for full discussion and deliberation. There is ACR and Court Monitor participation in office workgroups at the RST meetings. Typically, proposals are piloted at the office level prior to

presentation at the RST. Many of the recommendations that are presented by the membership are then ratified by the team for regional implementation.

Quarterly Provider Meetings

Region 3 meets quarterly with our larger contracted providers (CHC, CHR, C&FA, UCFS, USI & WCS). The purpose is to ensure that we are all aware of the current capacity, staffing and any concerns around contracts. We jointly problem solve to resolve any contract issues. We also discuss general themes around services, exchange general information around practice or themes we are experiencing. We also discuss results from our DCF staff surveys. The results are better communication and understanding of issues or concerns. It has also built more trust with the transparency of the conversations. These meetings are scheduled, agenda set and run by Jonathan Jacaruso, Region 3 System Program Director. Both the providers and DCF prepare data from PIE or other data sources. We review and discuss any differences and what might be causing the difference and a plan to rectify the differences. For the surveys we look at the comments from staff and scoring trends. *We review all contracts and all surveys received as well as* contract capacity utilization and DCF surveys on contracted programs. Copies are keep with Grants & Contract specialist who prepares report. In reviewing PIE data we discuss reasons for underutilization. Such as staffing or length of stay concerns. We also discuss the model itself and outcomes do our staff and families believe they are better off. We also look at the DCF survey results and discuss any concerning returns. We e-mail the results to providers. Reports are shared with providers. We also bring data to each offices monthly QIT meetings. These quarterly meeting have resulted in numerous changes. Based on these meeting we have created new contacts (Caregiver Support Teams) we have also help shape changes in Triple P scopes of Service. In some cases providers developed brochures of their programs for DCF staff so they can better understand what a service can and cannot do. It is also changed how we gate keep some contracts and keep staff regularly informed when we have contract capacity. These meeting have also been the catalyst to clarify statewide practice on contracts. As an example a provider informed us a PDOC told them it was ok to end an episode in PIE and start a new one if they required more time to complete the goals than the contract length of service indicated. The region was able to discuss with the PDOC that their suggested practice would corrupt the data and a statewide clarifying e-mail was sent out by the PDOC.

MDE Liaison

The purpose is to ensure all children in care receive an MDE within 30 days of placement and that QASW tracks all initial placements, which is the universe, and notifies the Foster Care Clinic MDE Coordinator of all new placements. This is the referral to Generations for the MDE. QASW coordinates with SW/SWS and Health Advocate who makes a referral to the other Foster Care Clinics when we place children outside of our service area, ensuring they have received the referral, that the appointment is scheduled, any paperwork is signed, receiving and distributing completed reports. QASW distributes MDE paperwork to SW's and makes attempts to ensure that it is completed in the specified time frame. QASW will include in this email to SW's a request to inform the QASW of any concerns that arise during the MDE process itself. QASW maintains ongoing contact with the Foster Care Clinic and troubleshoots issues such as, missing referrals, missing packets, unsigned forms, rescheduled appointments and verbal approval when a guardian cannot or will not sign the forms, etc. QASW distributes the completed MDE report (via email) to the ACR facilitator/ARG nurse/SW/SWS. QASW maintains a detailed excel log to track all aspects of the MDE process. There is no analysis performed. The information is used to ensure that no children are missed upon entry or due to rescheduling of appointments and to track trends by office or SWS/SWS/PM to inform the need for staff education in regard to this process.

MDE Follow-Up Meetings

The purpose of the MDE follow up meeting is for RRG staff to review the MDE recommendations with the SW and SWS and establish a plan in response to the medical, dental and developmental / behavioral recommendations identified within the MDE report. A determination is made if the MDE recommendation is relevant to the current functioning and needs of the child and a discussion about how to access any needed services. Upon receipt of the MDE report, MDE follow up meetings with the SWS, SW, RRG Clinician and RRG Nurse are scheduled. In Willimantic, FASU support workers are invited to this meeting as well. During the follow up meetings, the MDE recommendations are reviewed

and discussed. After the follow up meeting, the RRG Nurse places a summary of the meeting in a LINK narrative and emails it to QASW. QASW includes the MDE follow up meeting summary of recommendations when completing the Other Specialized Needs logs, in order to ensure that follow up occurs. This meeting is utilized to ensure that the SW and SWS are aware of the recommendations and that they have the opportunity to discuss any barriers regarding the recommendations and to develop an appropriate alternate recommendation in the event a service is not available.

MDE Quarterly Meetings

The Willimantic and Norwich Area Offices and their respective MDE clinics, meet once per quarter to review the quality and quantity of MDE's, as well as to discuss any outstanding service delivery concerns, or concerns with the Area Office performance regarding the MDE process. Middletown is in the process of establishing a process of meeting with their MDE Clinic on a quarterly basis. Currently, Middletown Area Office Director meets with the MDE Clinic Supervisor to discuss any presenting issues or concerns. In attendance is the QIPM, QASW, RRG Clinician, RRG nurse and MDE clinic coordinators, clinician(s) and Supervisor. Quantitative data is prepared by the MDE clinic and reviewed by meeting participants to ensure accuracy. MDE clinics maintain an in depth spreadsheet that is sent DCF Central Office to Dr. Wollman and Jane MacFarlane on a monthly basis. During the meeting this spreadsheet is also reviewed to ensure accuracy. Action plans are developed to discuss any concerns that are discussed at the meeting. The information is not housed or disseminated to staff or providers. The purpose of the meeting is to ensure that the clinic is adhering to the contract, that there is open communication between the clinic and the area office which impacts the quality and timeliness of MDEs occurring for children in our care.

Qualitative Case Reviews

A regional workgroup including 2 QASW's, 2 OD's, 1 SWS and 1 PM are currently working on a regional Length of Stay special project. The purpose of this project is to review data and identify factors that have contributed to a delay in achieving timely permanency. The reviews are looking at child's age at time of entry, current age, length of time in care, race/ethnicity, length of time to achieve permanency, current permanency goal or permanency goal at time of closing, length of time in care when goal was changed from reunification to another permanent living plan, reasons for delay in permanency, what SWS/Managerial direction was given and whether an ACRI identified permanency as an ANI. Thirty six cases were randomly selected and divided amongst a group of six staff to review. The reviews include looking at LINK narratives, legal icon, case plans, ACRIs and the case record as well as supplemental interviews with SW/SWS as needed. The data will not be housed, but is being tracked on a log. The intent is to use the findings to improve case practice resulting in more timely permanency outcomes for children and youth in DCF care.

ACR Activities

See statewide ACR QA Summary

REGION 4 RECURRENT and DEVELOPING QA/QI ACTIVITIES

Region IV Quality Improvement (QI) team consist of a program manager, supervisor, two social workers and the four Continuous Quality Improvement (CQI) Teams . In 2016, The CQI will include the regional FELT team and launch the Workforce Development CQI team. Each team is charged with reviewing regional data and recommending and implementing approved interventions in collaboration with regional leadership. As such, request for data are generated from this body who monitor, track and analyze for the purpose of improving regional performance. The frequency and dissemination of reports is monthly and provided to the regional management. =

Case Transfer Reviews

The QI Team reviews and reports on 50% of cases transferred from Intake on a monthly basis. The reviews focus on the race and ethnicity identification, fatherhood engagement, joint visitations, RRG consults and the delivery of timely services. It provides #% for each item and shared monthly with management. The QI team utilizes the DRS Link report and maintains the results in QI Supervisors S drive. The report is utilized to track and inform performance.

In home Case Review

The QI Team reviews and reports monthly on all In-Home cases that are not scheduled for an ACR. The reviews focus is on the case plan initialized, updated and approved, FSNA and Risk, family feedback and 90 day meeting. The data is collected from Link Reports. The report is disseminated via the monthly QI report and the #% for each item is charted by area office and manager. The report is utilized to track and inform performance.

MDE Reviews

The QI Team conducts a monthly review of all children in their fourth month of placement who received an MDE. The data is collected from MDE report, transferred onto an Excel spreadsheet that is maintained in the QI Supervisors S drive. The review captures the recommendation and the outcome. The QI team informs manager and supervisor of the results. Monthly, a summary and detailed report is generated and disseminated to regional management.

Children in Placement Reviews

Considered Removal Team Meeting Review

The Considered Removal Team, in collaboration with the QI Team, collects data on the number of CR meeting held and not held and the number of children placed for each element. For those not held, determine the reasons. The team utilizes the Teaming Link Report which is transferred to an Excel Spreadsheet. The spreadsheet is maintained by the Systems Program Director and QI Pm. The regional report that is shared with regional management.

Review of child Placement Data

The QI Team reviews the placement data monthly. The data is collected from the CIP data dashboard and transferred to an Excel Spreadsheet which is maintained by the QI PM. It tracks the number of children in care by race and ethnicity, gender, age, placement type and length of stay.

Review of Congregate Care Data

The QI team collects data monthly utilizing CIP dashboard. The team reviews the number of children compared to overall # of children in placement, the length of stay, race and ethnicity, and participation in area office permanency processes. The focus is on the reduction of children in congregate care.

Placement Diversion Review

The QI Team collects data from the Teaming Link Report and the CIP Dashboard monthly. The data is transferred to Excel and maintained by the QIPM S Drive. The Team reviews the number of children with recommendations to remain at home or under a family arrangement. # and % are captured and shared with the regional management team. The goal is to identify areas needing improvement (CR, family arrangements, legal).

Intake-Racial Justice Lens Review

The QI team, in the last quarter, conducted a review of completed intakes to assess the regions performance on the identification of race and ethnicity, engagement, and cultural consideration conversations. The team utilized the Link reports and transferred the information into Excel which is maintained in the QIPM S drive. The team reviewed # and % of information captured by Careline, at Intake, updated at placement or closing, service implications, supervisor discussion and documentation and the cultural consideration discussions and documented. The information shared with regional management team and reviews will occur every quarter.

Children ages 0-3 in-home

In 2016, the Team proposes to collect data to determine the number of children served in home under the age of three. The review will capture regional performance adherence to the region protocol, determine needs met, identify gaps in and effective services. The team explored utilizing the Educational Link Report for the baseline.

Preferred Permanency Review

The QI team collect data by age, race, and gender, length of stay and permanency goals utilizing the CIP data dashboard. The data is transferred to Excel which is maintained in the QIPM S drive. The review notes the number of children exiting care with a preferred plan, lifelong connection, participated in OPPLA, Permanency Round Table and Community Based Life Skills program. The information is shared with regional management team and informs the office performance achievement.

Regional Reunification Provider Review

On a monthly basis, the Systems PD collects data from the regional contracted provider to insure the effective use of the program and measure the regions reunification performance. The data is maintained by the System PD and

the QIPM S Drive. The review includes the utilization of the program, capacity, commencement and completion time frame with outcomes. The information is shared with regional management team.

Fatherhood Engagement Review

The FELT team reviews the cases transferred from Intake to determine the frequency and quality of visits; effective location, contact and engagement of fathers and assessment of needs. The data is gathered from Link Reports, transferred to Excel and maintained in the QISWS S drive.

Review of the SBAC- (Achievement level, graduation, expulsion, retention)

In 2015, the Team will review the data provided by Central Office with a goal to establish a baseline of regions performance. The data will be used to understand the barriers (study), develop strategies, identify partners and training needs for partners and identify resource needs.

Supervisory Conference Reviews

The Program Managers review 1 session agenda per Social Work supervisor monthly. They review the supervisory agenda, area of discussion needs met and engagement. The data is located on the monthly OD reports. The analysis of the data includes a review of conference notes, address performance issues, quality of supervision and case planning.

Employee Surveys

Supervision Feedback Tool

The Professional Development Committee developed a Supervision Feedback tool in 2014 which is administered to all regional staff semiannually via SharePoint survey. The questions are related to the principles of partnership and cross cutting themes. Staff complete this voluntary tool for their supervisor/manager. The results are compiled by the QI SWS and each supervisor and manager is given a compilation of their own results to use for their own personal and professional growth. Each manager is given a compilation of the results of their supervisors.

Staff Satisfaction Survey

The Staff Satisfaction Survey is administered annually via Survey monkey for all regional staff. The result of the survey are reviewed by management team, presented at staff meeting, conduct focus groups and establishment of a team to increase staff satisfaction.

PM Reviews

Each Program Manager Reviews one case that is mid-way through the case planning period under review using the PM review tool that addresses visitation, engagement, needs met, supervision, family connections and consultation/referrals. The data is entered on a spreadsheet by QI SWS and the number of strengths and ANIs for each rating are compiled for the region and reported on the monthly QI reports and quarterly at the Case

Planning CQI team meeting. The managers review the results with the SW and SWS and themes with their workgroup.

PM Reviews of ACRIs

Each Program Manager reviews 15 ACRis per month. The data is entered on the OD monthly reports. The managers use the data to identify strengths and needs, performance need and review the results with their SWS.

Court Monitor Presentation

The court monitor reviewers come to each workgroup meeting in the region once per quarter to review a case with the workgroup using the PM review tool. There is an open dialogue between area office staff and court monitor staff, exchange information and identify the strengths and areas needing improvement on the case.

90 day meetings

Each supervisor reports the number of 90 day meetings due for the month and how many were held on a tracking log and turn in to their manager. The manager reports on the monthly business report and the ODs report to QI on the monthly OD report. The percent of 90 day meetings held is reported at the quarterly Case Planning CQI team meeting.

Case Practice Report

Each quarter the QI SWS pulls the items on the case practice report from LINK reports identified by the Case Planning CQI team in order see if there is improvement each quarter. The percentage of strengths for each item is reported quarterly at the Case Planning CQI team meetings.

SWS ACRI Review

Each month the supervisor enters on their tracking log the number of ACRIs received for the month and the number that they reviewed and submit to their manager. The manager reports on the monthly business report and the ODs report to QI on the monthly OD report. The percent of ACRIs reviewed by the supervisors will be reported at the quarterly Case Planning CQI team meetings.

REGION 5 RECURRENT and DEVELOPING QA/QI ACTIVITIES

1) Monthly <u>CPS/ACR Case Planning Meetings:</u>

Results that support the achievement of OM# 3 and # 15, Better Outcomes for our Children and Families: these collaborative meetings include our Court Monitor Liaison, interdisciplinary team; specifically Educational Consultant, RRG, FASU, Permanency Specialists and Legal when indicated. These are monthly collaborative team skill building forums with avid discussion on meeting the planning needs of our families, and staff informed on identification and service provisions and documenting such. Results of these meetings include improving the skills on writing case plans, consistently knowing what to enter in each of the domains, and engaging the family with the case planning process. Also looking to ensure that we are referring to the individualized, specific services, and the documentation of this service is evident feedback/ progress in the case plan.

Frequency of this Activity: These ACR/CPS forums are monthly in each area office.

Who is Responsible for Carrying out this activity: The ACR PM schedules these monthly meetings with CPS PM and AD. The AD's and PM's engage in the topic selection based on the identified need, and follow through with staff continued awareness of the importance of the continuous improvement needed.

What Methodologies are used: PM's monitor their staff performance with case planning elements via SharePoint, and the ANI's are reviewed. Themes are presented by the ACR SWS's to assist with patterns of required follow up.

Data: The data that is collected comes from Share Point, All Elements ACR Report**.**

Analysis: The QI/QA analyzes patterns with the Area Office staff monthly and review themes coming from the Share Point report, including the ACRI's that the PM and SWS's are reviewing. The RD and AD's review the Court Monitor feedback and shares the themes and data at our regional quarterly meeting with all Supervisors and Managers.

Activity to Inform Change: The findings of the ACR Share Point report specifically demonstrate change, (+ / -) and the effectiveness of the interventions of the ACR/CPS monthly meetings.

2) QI Review of Court Monitor Response

Results of this Activity: CPS SW/SWS/PM have the opportunity to respond to clarifying questions following the blind review. CPS PM and QIPM review the responses for accuracy and detail to inform the Court Monitor about our practice and the best practice and outcomes for our children and families

Frequency: Quarterly

Responsible Person for carrying out the activity: The QIPM reviews the final response and sends this to the Court Monitor

Data: This is collected when the final results are released. This is further discussed in # 3 (see below)

Analysis: The review responses are collected and themes analyzed for patterns by unit

Reports Shared: Each PM shares their written responses from each case with their unit, as a learning experience

Activity to Inform Change: Shared themes are reviewed and an engaging discussion about ISP's needed, vs. skill building and support/guidance and coaching from the PM, QI/QA or ACR SWS

3) Court Monitor CPS/Multidiscipline Meetings with the Court Monitor

Results are Intended to Achieve: Improved Outcomes for our Children and Families, and passing OM 3 and 15

Frequency of this Activity: Quarterly

Who is Responsible for Carrying out this Activity: QIPM schedules these meetings with the RA, Court Monitor, and all disciplines within our Regional Staff

What Methodologies are used: Court Monitor reviews, and the written responses, themes and patterns are highlighted and reviewed

Universe size: Danbury and Torrington each have 2 cases selected, the Waterbury Office has 5-6 per quarter

Data: The case reviews are selected for the Blind Case Review performed by the Court Monitor's Office

Analysis: The review responses are collected and themes analyzed for patterns by unit

Reports Shared: Each PM shares their written reports from each case with their unit. The RRG, FASU, Legal and Permanency Coaches review all of these reports

Activity to Inform Change: RA leads these quarterly meetings, and shares the themes of the Court Monitor findings and engages AD's, PM's and SWS's in an engaging discussion about ISP's needed, vs. skill building and support/guidance and coaching from the PM, QI/QA or ACR SWS

4) ACR OA System to support SWS Case Plan Approval

Results are Intended to Achieve: A back up system to ensure that all SWS's are reviewing and approving their case plans timely

Frequency of this Activity: Bi weekly report

Who is Responsible for Carrying out this Activity: ACR OA to the QIPM for follow up by the CPS PM. The loop is closed when the CPS SWS emails the QIPM and CPS PM that the outstanding case plan approval has been completed

What Methodologies Used: ACR Data from SharePoint, ACR OA goes into every LINK case with an ACR (in home and out of home) held and determines if SWS approved

Universe Size: Entire ACR in home and Out of Home schedule

Data: Every case with ACR LINK is reviewed for case plan approval, at least 20 days post ACR

Analysis: QIPM maintains log of overdue case plan approvals by CPS SWS, excel log can be sorted and shared with CPS PM for follow up. Trends are noted for ongoing SWS's needing support and reminders to approve case plans

Reports Shared: The excel document is distributed to the CPS PM for follow up with the CPS SWS

Activity to Inform Change: With the use of this excel tool supporting the CPS SWS's existing method to approve case plans, there are minimal case plans needing approval beyond the designated timeframe. When there is however a case plan overdue for approval, this system supports immediate attention by the CPS SWS for follow up

BOB Babies on Board

Results are intended to Achieve: A proactive approach in triaging cases with the highest case risk, our 0-3 child population

Frequency of this Activity: BOB Team meets monthly

Who is Responsible for Carrying out this Activity: SWS Carey is Chairperson for this pilot, there are CPS multi disciplines from the region as standing members, as well as external stakeholders

What Methodologies Used: Protocol for FAR cases with a highlighted focus on DCF involvement, risk factors, protective factors, and critical thinking to this very young, vulnerable population. The multidisciplinary approach and critical thinking is the discussion for supporting the case strengths and 'thinking outside the box' and 'meeting of the minds' discussion to determine if any enhancements can be made to the assessment work

Universe Size: Selected FAR cases with a multidisciplinary review of children 0-3 years old with a very low/low risk SDM status and a pending closure

Data: Repeat Maltreatment, were there subsequent reports and/or maltreatment on these cases when we look back at a six month period. If the case was referred back to the agency, was it closed out? Transferred? And were children removed? Also we would need to determine the outcome of these cases. A master's level intern will assist with the data collection

Analysis: Collecting and analyzing the information for low risk FAR cases. During the presentations there is multidisciplinary feedback and external stakeholder input. This data will be maintained for 6 months

and reviewed for analysis of repeat maltreatment, case disposition and children's assessment following this FAR protocol review

Reports Shared: Following the six months, the data will be reviewed and analyzed. Team and staff will share reports and analysis, sharing 'lessons learned' and positive casework

Activities to Inform Change: Presenting cases to the BOB team will encourage staff to apply critical thinking skills to this very vulnerable population (children ages 0-3). This information learned from this FAR low risk case review, will broaden the team's sphere of influence beyond the referred FAR cases

5) Case Plan Coaching (Starting Dec 2015)

Results are intended to Achieve: Improved performance with our Performance Expectations, positioning us for Exiting Juan F, and having improved outcomes for Families. Our Region is undertaking an intervention to turn the curve in case planning, we are inserting managers as coaches in the case practice to enhance the work with families. This will be accomplished through PM facilitating an internal team of the case planning with the SWS and the SW 60-90 days before the ACR's. The following areas of practice will be an area of focus and be considered in the teaming: Visitation, Engagement in Case Planning, ACR Attendance, Needs Assessed/Addressed, Consultations and Child and Family Teaming

Frequency of this Activity: Monthly CPS PM reviews themes of upcoming ACRI's for the month

Who is Responsible for Carrying out this Activity: ACR OA pulls ACR calendar in advance and gives this information to CPS PM

What Methodologies Used: To be further assessed, CPS PM's will be documenting this review/consultation

Universe Size: All ACR's as scheduled

Data: the collection of this data to include analysis of assessing of engagement, visitation, needs assessed and addressed, consultations, and child and family permanency teaming

Analysis: to be determined

Reports Shared: CPS PM to discuss themes of ANI's with staff in preparation of the upcoming ACR and completion of the case plan with the family.

Activity to Inform Change: This coaching by the CPS PM in preparation of the ACR supports positive change and the permanency case goal movement, and needs met. The change will be noticed in the Share Point site and better outcomes for families, including fewer repeat maltreatment cases, fewer case re openings and substantiations and expedited path to child permanency

6) Region 5 FELT Team

Results are Intended to Achieve: Engaging father's in the case planning and best case practice daily activities

Frequency of this Activity: Monthly meetings and quarterly statewide meetings with our regional FELT members

Who is Responsible for Carrying out this Activity: All staff during their typical daily case practice

What Methodologies Used: ORE, Quality Council and Statewide FELT are in the process of creating QA questions for a review, potentially part of the EPOM # 1 & 2 review

Universe Size: All cases

Data: To be collected once review is finalized by ORE and QI Council

Analysis: To be performed by QI/ORE

Reports Shared: Results will be shared once review finalized

Activity to Inform Change: Improve our practice to all fathers engaging in the case planning and involvement with children

6) OA ACR Schedules and Shares Report with All Disciplines

Results Intended to Achieve: Sharing the ACR report (proposed date up to 2-3 months early) with all disciplines including CPS up to Management level, as well as RRG, DV, Nursing, and FASU. This supports a collaboration of the case planning with the family, as well as all disciplines involved. RRG and FASU attend the ACR's when allowable and collaborate with the team and planning

Frequency of this Activity: The ACR OA creates this shared ACR list 2-3 months in advance of the ACR

Who is Responsible for Carrying out this Activity: ACR OA

What Methodologies are Used: ACR OA pulls this information from their schedule and shares this information with all offices in the region

Universe Size: All cases

Data: All disciplines share this schedule to support the planning and collaboration with the child/family

Analysis: Refer to implementation of PM Coaching

Reports Shared: ACR OA shares the ACR schedule with all disciplines

Activity to Inform Change: This heads up helps keep the ACR date live and ready for active case planning with the family/stakeholders. Preparing for this ACR during home visits with the plan supports the 'live case planning' with child/youth/family/all DCF disciplines and stakeholders

7) Monthly Review of Youth 12 and under in Congregate Care

Results are Intended to Achieve: Collaborating with RRG, CPS and FASU to discuss planning and discharge options on cases where youth are in congregate care and 12 and under

Frequency of this Activity: Monthly Team Meeting

Who is Responsible for Carrying out this Activity: RRG, CPS and FASU collaboration (QIPM reports out the final information to RA)

What Methodologies are Used: Tracking the planning on an excel document, labeled by date to show the progression of the case activity and movement

Universe Size: All children on the Data dashboard in Congregate Care 12 and under

Data: Data dashboard is primary source of this information

Analysis: Review of the children 12 and under in CC and the progress discussed and documented on the excel form, showing the barriers, planning and case movement

Reports Shared: This report is shared with the RA and ultimately is shared with the DCF Commissioner

Activity to Inform Change: Children will be discharged successfully from congregate care timely, with efficient, collaborative discharge planning

8) Permanency Teaming

Results are intended to Achieve: Teaming with the family, DCF and Stakeholders at the onset of case involvement, and carrying on throughout the life of the case, supporting placement and contact with as much family as possible. Involving WWK, and our Regional ARE Social Worker to support case mining searching for relatives, kin and supports

Frequency of this Activity: Large Team meetings followed smaller teamings with the family and stakeholders meeting on permanency and family involvement. Referrals and engaging WWK and ARE as needed to seek out family and supports for permanency planning

Who is Responsible for Carrying out this Activity: CPS staff plan for and coordinate the team meetings, invite collaterals, multi-disciplines and extended family

What Methodologies are used: Every case needs permanency teaming and documentation of this planning

Universe Size: All cases, in home and out of home

Data: LINK to support the Large Team Meetings category, then ORE to assist with pulling this data

Analysis: To be determined

Reports Shared: To be determined once data is collected and analyzed

Activity to Inform Change: Permanency Teaming will lead to improved connections and placement with family, and case permanency goals achieved sooner

9) Icebreakers with FASU

Results are Intended to Achieve: Promote relationships between the biological and core foster homes working on the permanency goal and better outcomes for the child

Frequency of the Activity: At the onset of the Permanency Teaming with all Core foster homes and biological families

Who is Responsible for Carrying out this Activity: FASU schedules these icebreakers with the biological family and the CORE family. CPS and FASU, and facilitates the meetings

What Methodologies are used: Facilitation and support of the foster homes with the biological family. The meetings are tracked by FASU staff

Universe Size: All CORE foster homes are to have ice breakers with biological families

Data: Excel documentation to support meetings held and those scheduled, data is being collected to support this work

Analysis: To be determined

Reports Shared: Excel tracking to be shared with FASU PM and Systems PD for accuracy and identification of any barriers to these meetings

Activity to Inform Change: Relationship establishment and enhancement to support the placement in the CORE foster home and prevent disruptions, and expedited permanency goals planning with everyone involved and planning together

10) 6 Month Review of Report of in Home Cases Open 6 months +

Results are Intended to Achieve: Program Managers pulls the 6 months in home report with no legal action to assess for case planning and closure vs. legal consultation and further determination of case status

Frequency of this Activity: At the six month mark, cases on the LINK Report are reviewed and assessed for closure vs. legal intervention

Who is Responsible for Carrying out this Activity: CPS PM / SWS and SW review these identified cases and move toward closure or legal intervention. QIPM oversees this activity and cross checks the log for ongoing children remaining on this LINK report for more than a month

What Methodologies are used: Review of LINK reports and assessment of identified of cases. SDM risk level is also analyzed

Universe size: All children categorized as being as an in home case, with no legal intervention and case remaining open

Data: LINK reports tracks these specific in home cases

Analysis: Patterns of cases open longer than six months with no legal intervention and SDM risk levels identified

Reports Shared: PM shares this report with their SWS and SW staff to support movement of these cases and goal achievement

Activity to Inform Change: Case goals will be achieved timely

11) MDE documentation and follow through with Recommendations

Results are Intended to Achieve: Child/youth will have full screening within their first month of placement, and recommendations for follow up with their care

Frequency of this Activity: All children/youth entering placement will have a timely MDE scheduled and this occurs within 30 days of placement

Who is Responsible for Carrying out this Activity: FASU sends the name of the child/youth placed to MDE coordinator who schedules this MDE with the caretaker and child/youth. RRG and CPS SWS support the follow up with the recommendations.

What Methodologies are Used: Weekly review of ROM and comparison of CIP LINK reports to ensure all children in care are having their MDE as indicated

Universe Size: All children placed in care, unless are defined in an exception category with a N/A code

Data: ROM report confirms MDE entries into LINK by designated CPS SW

Analysis: Themes reviewed with QI and Systems PD re: getting MDE's timely. Checking into ROM, and quarterly LINK reports

Reports Shared: ROM is reviewed by Systems PD and QIPM to ensure the measure is 100%. If not, the barrier is identified and progress to meeting this outcome is achieved. CPS SWS incorporates the recommended follow up into supervision and consults with RRG as needed

Activity to Inform Change: Identifying and meeting all of the children/youth's needs at the onset of placement. These needs are identified and followed up on as a part of the child and family case planning

12) Relative Resource Search

Results are intended to Achieve: All cases will have relatives/kin/supports identified for them as a part of case planning with the families. This search is intended to ensure that all supports are available to our individual youth and families at the onset of our case planning

Frequency of this Activity: This resource icon is completed at the onset of our case involvement, and again reviewed continuously as a part of the Permanency Teaming and Considered Removal Child and Family Teamings

Who is Responsible for Carrying out this Activity: All CPS staff, and FASU staff to include their Relative Checklist Firewall search, prior to any child/youth being placed. The child/youth not placed in relative care is the exception and the CPS PM needs to sign off on this firewall to show that all efforts have been made to place with relative and/or kin

What Methodologies are Used: ROM reports determine cases with a resource icon entered in LINK

Universe Size: All cases

Data: ROM shows cases with a resource icon documented in LINK. Considered Removal Data includes family/kin/supports as identified by the family in the teaming documentation, and the FASU Firewall is entered into the Resource Icon

Analysis: QIPM and Systems PD reviews ROM (OM # 4) for completion and 100% as an average for statistics, as all cases need this icon completed

Reports Shared: QIPM and Systems PD share ROM as needed to ensure follow up on any outstanding Resource Narratives

Activity to Inform Change: Children/Youth having all relatives, kin and supports identified to ensure smoother transition to permanency and the optimal planning with all family and supports involved

13) Visitation Tracking

Results are Intended to Achieve: Social Workers seeing their cases, in home and out of home as per policy. PM's oversee the LINK reports, Share Point and ROM to determine the percentage of cases, in home and out of home cases seen and documented by the SW

Frequency of this Activity: CPS PM and QIPM reviews this LINK visitation report at least monthly to determine standards met within the units

Who is Responsible for Carrying out this Activity: CPS PM reviews the reports, and discusses the outstanding cases needing visitation documentation with the Social Work Supervisor. QIPM reviews the reports at the end of the month for oversight of this visitation and compliance

What Methodologies are Used: Share Point, LINK reports and ROM shows cases meeting these measures and those needing the visitation/ documentation in LINK

Universe Size: All cases

Data: This is evident in LINK Reports and ROM

Analysis: LINK and ROM visitation reports can be exported into excel and this visitation report can be drilled down by name as to entries needed

Reports Shared: Share Point, LINK reports and ROM can be viewed by all CPS staff, as a tool for supporting all cases documented in LINK

Activity to Inform Change: Tracking visitation by CPS PM and the discussion of outstanding visitation documentation supports families seen timely, purposeful documentation and better outcomes for our children and families

14) BHPD call weekly reviewing Congregate Care and D/C Planning

Results are Intended to Achieve: Reduction in Congregate Care

Frequency of this Activity: Weekly reviews, however the selected individuals are discussed monthly

Who is Responsible for Carrying out this Activity: BHPD

What Methodologies are Used: RRG Team reviews cases and documents progress and identifies treatment and updates, as well as barriers to the discharge planning

Universe Size: All children in Congregate Care

Data: Data Dashboard shows all children/youth in congregate care

Analysis: BHPD, CPS, FASU and RRG reviews cases and planning for treatment and discharge planning

Reports Shared: Data Dashboard

Activity to Inform Change: Reduction of children/youth in congregate care

15) NYTD Surveys

Results are Intended to Achieve: Support to IV-E planning, and an assessment of the results/outcomes of our youth who transition out of our care

Frequency of this Activity: Cohort is pulled by CO, information is reviewed monthly

Who is Responsible for Carrying out this Activity: SW Liaison with QIPM oversight

What Methodologies are used: CO and Feds assess the survey results

Universe Size: Cohort is pulled for each Area office by CO

Data: Surveys are completed by assigned SW for open adolescent cases, and closed cases are completed by SW Liaison to this process. The data is entered into Case Planning Survey Icon

Analysis: Analysis is completed by CO

Reports Shared: CO has reports from NYTD analysis shared with regions

Activity to Inform Change: Data supports our planning results for our adolescent youth at ages 17, 19 and 21

16) 550-1 Title IV-E Reimbursement:

Results are intended to Achieve: Tracking, compliance and follow up with 550-1 reimbursement on cases

Frequency of this Activity: Monthly

Who is responsible for carrying out this Activity: Social Workers

Methodologies, Universe size, Data, Analysis, and Reports all completed by CO and results are shared regionally to support our compliance with IV-E reimbursement funding

17) Social Security/SSDI Reimbursement:

Results are intended to Achieve: completing SSI/SSDI applications and reviews by the Social Work Liaison, to ensure appropriate benefits are connected and follow the child/youth

Frequency of this Activity: All children/youth entitled to these benefits will have an application completed and follow up with required paperwork

Who is Responsible for Carrying out this activity: Social Work Liaison initiates the application process, gathers the required information, and supports the social worker in connecting the benefits to the child/youth

Methodologies, Universe size, Data, Analysis, and Reports are tracked by the Social Work Liaison as to initiation of application, pending status and completion

18) Runaway Database:

Results are intended to achieve: Accurate count documented in LINK reports for the AWOL youth, and ensure protocol is in place for each case

Frequency of this Activity: SWS's review this database every 2 weeks or sooner based on case activity and risk

Who is Responsible for Carrying out this Activity: Social Workers update the database. QIPM reviews to ensure updates are timely

Universe size: All youth on AWOL status get entered onto the SharePoint LINK database

Data and Analysis: Pending the update of the LINK Share point site in LINK as assisted by ORE

Reports Shared: The updated report is shared monthly with our Regional Director along with the age 12 and under youth in congregate care excel document

19) CFSR pilot by designated staff:

Results are Intended to Achieve: Improvement with identified areas of case practice concerns as noted by the Federal Government in prior reviews and the PIP

Frequency of this Activity: Monthly CFSR cases as informed by CO

Who is Responsible for Carrying out this Activity: Designated, Trained Reviewers

What Methodologies are Used: As determined by ORE

Universe size: As determined by ORE

Data, Analysis, Reports and Change as indicated/informed by ORE

20) Considered Removal Log and Tracking:

Results are Intended to Achieve: Amount of Child and Family Considered Removal Meetings held, the amount of placements diverted and all information broken down by race/ethnicity, household composition and safety planning

Frequency of this Activity: Each Teaming is held when safety issues/imminent risk or removal is evident in our cases

Who is Responsible for Carrying out the Activity: CPS PM decides on the Teaming. Facilitator holds the meeting with the family and any supports/ stakeholders

What Methodologies are Used: QIPM analyzes monthly data to determine how many teamings are held, when the meeting is held and the outcome of the meetings held. Other data analyzed include race, family composition, prior DCF history and placement, etc.

Universe Size: All cases to have a Teaming, with safety issues and imminent risk of removal

Data/Analysis/Reports Shared: This information is shared with Senior Leadership and a part of the quarterly Commissioner's presentation

Activity to Inform Change: The story behind the data can reveal information that can help with our overall work with children and families, e.g. more services in locations to prevent removals

21) QI Investigations/FAR Review Proposed Plan:

This review of Investigations Case Review is slated to begin within the next few months, pending ORE development of the review tool and analysis. The purpose of the Investigations Case Review is to gain an assessment of the quality of the intake and investigation process, as well as compliance with DCF policy and practice requirements. The reviews will also be used to identify staff training needs, policy development, and system improvements. To encourage and support staff in improving skills in serving clients and in managing agency resources

The review tool is being developed by ORE and the statewide CQI with the intent to identify the following: High quality assessment, critical thinking and engagement that respects the client's unique needs and circumstances. Use of best practice techniques. Use of and possible amendments to current policy. Case Practice evaluation to identify ongoing barriers and areas needing improvement.

The process required to be used with the tool and review involve

- A qualitative and quantitative assessment pertaining to the thoroughness of the intake process along with the accuracy of the investigations disposition and use of assessment tools (SDM).

- An assessment of services provided to the child (ren) and caregiver(s) and their effectiveness in addressing the identified needs.
- A qualitative assessment of the caseworker's engagement with the family and caregivers.

Type and Number of Cases Reviewed Bi-Monthly

A random sample of cases will be selected for review. The criteria for selection will include:

- Age of child
- Closed within 30 days/ or Still open
- Substantiated and Unsubstantiated
- Type of Report (FAR, Intake)

Within 45 work days of the review CQI will discuss the findings. The report will address the following:

- Identified patterns and trends
- Strengths and areas for improvement regarding quality practice
- Best practices noted
- Compliance with DCF policy
- CQI recommendations for enhancements or changes in practice, policy and/or procedures
- Sample of cases that go over the 45 day mark to assess barriers to timely completion

REGION 6 RECURRENT and DEVELOPING QA/QI ACTIVITIES

DCF Region 6 includes the New Britain and Meriden area offices. The New Britain office serves 14 towns (Avon, Berlin, Bristol, Burlington, Canton, Farmington, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Southington, and Wethersfield). The Meriden office serves 2 towns (Meriden and Wallingford).

As of December 2015, there are approximately 550 children in placement in Region 6, 180 in Meriden and 370 in New Britain, with 42% in foster care, 34% in relative/kinship care, 16% in congregate care, and 8% in Independent Living. Region 6 caseload is approximately 1,961 cases, representing 13.3% of the statewide DCF caseload. New Britain is the 3rd largest office in the state in terms of caseload at 1,361 cases. Regionally, there are 142 social work staff, including trainees – 39 in Meriden and 103 in New Britain. Oversight of their work is done by 34 social work supervisors and 14 managers region-wide, who are also responsible and involved in the following quality assurance activities.

0-3 Protocol/Reviews

Region 6 developed a Zero to 3 case review tool to review all cases coming to intake with a child that falls into the 0-3 age range. The ISWS and ISW apply the tool to the case during formal supervision after the ISW has initiated the investigation. In addition, the two intake Program Managers randomly review 15 to 20, 0-3 case closings per month and apply the tool as they review. All transfers to ongoing services with children 0-3 are reviewed by the Program Manager and the tool applied. The findings of the review are documented in the case record LINK narrative as a supervisory conference note which is done on 100% of all intakes with a child age Zero to Three. The Program Manager documents findings in the LINK narrative as a managerial note.

The Zero to 3 review tool looks at the following: Age of each parent, Age of the child, DCF history, Parental history of trauma as a child, Parental DCF history, Mental Health issues as they pertain to each parent, and Substance abuse issues as they pertain to each parent. The Social Work Supervisor writes a narrative into the LINK case record discussing each of the above points, the impact of those findings on the child and any services in place to support and/or protect the child(ren). The goal of the application to this tool is to be sure that pertinent risk factors are assessed carefully and promptly during the investigation. Subsequent to the review, the ISWS and ISW will discuss appropriate safety planning given the risks identified.

The methodology of the 0-3 protocol includes the following steps:

1. Identify 0-3 cases at Intake.
2. SWS to document the presence of increased risk factors, develop a safety plan and plan for SW home visitation.
3. SW to complete 0-3 Parent-Child Assessment Tool monthly for children ages 0-1 and every 3 months for children ages 1-3, until the youngest child in the home reaches age.

4. SW to utilize 0-3 Parent-Child Assessment Tool during parent interviews.
5. SW to provide parent with printed information on safe sleep, shaken baby, child development and parenting tips for healthy development (CDC) with the PRTK pamphlet.
6. ARG consult to occur on all 0-3 cases where a MH/BH/SA/DV need has been identified for the caregiver(s).
7. Legal consult to occur on all 0-3 substantiations.
8. 0-3 case transfers to ongoing services are flagged and the increased risk factors, safety plan and SW visitation plan are discussed during the transfer conference and documented.

The supervisory/managerial role is as follows:

1. Monthly supervisory conferences to occur until the youngest child in the home reaches age 3.
2. Managerial consults to occur every 90 days until the youngest child in the home reaches age 3.
3. Ongoing assessment and documentation of the presence of increased risk factors, safety planning and SW visitation plan specific to the needs of the case.
4. SWS to maintain a tracking system for all 0-3 cases within the unit.
5. PM to maintain a tracking system of all 0-3 cases within the workgroup.

The information obtained through this process is then discussed in investigations workgroup meetings with a focus on methodology to strengthen the family interventions to best ensure the safety of child(ren). It is also disseminated through discussion during regional Executive Team meetings with a focus on review of the themes and interventions utilized. Significant points from this discussion are brought forward and incorporated into ongoing zero to three case practice.

Intake Quality Improvement Process

The purpose of the Region 6 Intake Case Review is to gain an assessment of the quality of the intake and investigation process, as well as compliance with DCF policy and practice requirements. The reviews will also be used to identify staff training needs, policy development, and system improvements.

The current Region 6 review tool is based upon the OM1/OM2 Pre-certification tool initially developed by the DCF ORE Division and statewide CQI committee. The process required to be used with the tool and review involve:

- A qualitative and quantitative assessment pertaining to the thoroughness of the intake process along with the accuracy of the investigations disposition and use of assessment tools (SDM).
- An assessment of services provided to the child(ren) and caregiver(s) and their effectiveness in addressing the identified needs.
- A qualitative assessment of the caseworker's engagement with the family and caregivers.

To maintain the integrity of the CQI process, the following controls will be put in place:

- All review staff will be trained in the process prior to participation in a review.

- The regional QI staff will randomly review cases to ensure that the tool is being scored correctly for completeness and consistency.
- As required, the assigned CPS staff (PM, ISWS, ISW) will participate in a learning forum to review the results.

The methodology of this process is as follows: each month the intake program managers will review a minimum of 9 cases using the Intake Tool, New Britain – 6; Meriden – 3, consisting of 6 closed and 3 transferred cases, including 3 FAR cases in the sample. The criteria for selection will also include at least one case per Intake Supervisor. The completed tools will be forwarded to the OD's with their monthly business reports for review. The OD's and regional QI staff will identify patterns and trends, and note strengths and areas needing improvement. An analysis of cases that exceed the 45 day mark will also be done to identify barriers to timely completion.

Case transfer protocol

The New Britain area office recently moved away from formal in office transfer conferences to a more inclusive home visit model. It was determined that transfer conferences would be more beneficial to both the ongoing DCF social worker and to the family by taking the form of a purposeful home visit. Upon receipt of a new case from intake, the ongoing SWS contacts the intake SWS to discuss the home visit and initiate contact between the ISW and the OSW. The ISW and OSW contact the family and schedule a joint home visit which will serve as the transfer conference. The goal is to have this occur on 100% of cases newly transferred from intake to ongoing services. It is also the goal that this joint home visit will occur the first week after transfer and will be the OSW's initial contact with the family.

The joint home visit covers several specific topic areas: why did DCF initially get involved, and why was the family case transferred to ongoing services, focusing on the specific safety concerns that will need to be addressed by the ongoing social worker. There is discussion with the family about current services in place and services that the OSW will be discussing further with the family as the case plan is developed. The family is also encouraged to ask any questions they have regarding the intake assessment and reason for transfer. The family is also encouraged to give feedback as to how they see DCF supporting and strengthening their family. This process has reduced the family splitting between intake and ongoing services. Family feedback has indicated an increase in understanding of DCF concerns regarding their family. This process will also accelerate the interventions with the family and lead to case closure sooner.

This model has been in place for approximately three months as of December 2015. This process was adopted due to concerns that the transitional in-office transfer conferences were not happening until after the OSW had already made an initial home visit and after informal discussions between intake and ongoing services workers. This made the traditional case transfer conference redundant and not an efficient use of time. It was also felt a formal joint meeting with the family would begin the teaming approach and help the family see that the DCF SW shared the same concerns regarding their family. The intake team has discussion about this process and plan to modify it as needed to best meet the needs of the family and produce the most seamless case transfer possible.

This process is tracked by the program managers maintaining a case transfer log. This log captures the last ISW home visit, legal action (if any), date of case transfer, intake track at time of transfer, compliance with OM#2, 0-3 year old children in the home, and date of the joint home visit. This data will be utilized to continue to modify and improve case practice with respect to case transfers from intake to ongoing services. The Meriden Office continues with the traditional transfer protocol but is adopting the joint home visit process as well.

90 Day Reviews

The Quality Assurance Manager sends out monthly reminders to all CPS Program managers and Social Work Supervisors of 90 day reviews due for that month. The CPS worker meets with all family members at their home and reviews the entire case plan. The case plan is then updated at that time with any changes or additions. The meeting with the family is documented in LINK.

The CPS SWS also discusses the case in supervision on or about the 90 day mark and reviews the case plan with the SW. Directives are given as needed and entered into LINK narrative as a supervisory conference. There is a focus at this time on progress being made with all goals and objectives and these can be updated as needed based on the family's progress or lack thereof at that time.

The SW makes a follow up visit to the family and engages in discussion around the supervisory changes recommended as well as family's view of their progress. Updates and changes to the case plan are discussed and the goals and objectives are revised as needed to ensure that all needs are being addressed. Progress made on these objectives is noted in the home visit narrative and/or 90 day meeting narrative as well as being documented in the case plan if there are changes.

Program Manager Reviews

Regional program managers submit monthly business reports that detail the following oversight activities: Individual Support and Work Plans issued to staff; Quarterly Qualitative Case Reviews; ACRi's Reviewed in their workgroup; Supervisory Agendas Reviewed; Group Supervisions; and ACR and/or Court Monitor Collaborations. The reviews noted identify staff who require assistance with case planning, and how best to provide support for improvement. The qualitative case reviews and review of ACRi's identify problem areas with In Home, Out of Home, Investigation and FAR cases. All of these activities are aggregated office and region wide and entered into an Excel database by QA staff. This data that shows trends and patterns among staff and case performance is distributed and shared during regional executive and leadership team meetings.

The QA staff also receive and review each and every ACRi issued through the ACR process, logging all case practice areas identified as needing improvement. These areas are aggregated by type of case and month, and can be drilled down to office, manager, supervisor, and worker. These findings and trends are distributed to office managers and supervisors on a monthly and quarterly basis.

Quarterly 3/15 Case Reviews with Court Monitor's Office

The objective of the CM meetings and learning forums is to provide a strength based approach to group supervision with a focus on case planning OM3 and 15. Each quarter, the he Court Monitor staff review

5 cases for New Britain and 2 cases for Meriden to assess the quality of case planning and meeting the identified needs of the children and families involved with the Department. Each PM shares the written reports from each case with their units. The learning forums allow the supervisors and units to look through the lens of ACR and CM in evaluating case plans and practice. These meetings occur on a quarterly basis and as requested by the individual program managers for their work groups. This process is managed by the Area Office Directors, QA Manager, and ACR Program Manager. CPS staff have the opportunity to respond to the court monitor review results and to clarify the reasons behind the ratings. OM3/15 data is collected and reviewed during management, leadership and work group meetings, and is reflected in the regional strategic operational plan. This data is also used to help determine the need for work plans and individual support plans for staff.

Kinship and Fatherhood Firewalls

The kinship firewall is a process developed to help staff identify and locate relative/kinship resources when considering placement of children as a means to increase our relative/kin placements. This form must be submitted to FASU indicating efforts made to locate/identify relatives and kin. During this process CPS staff must:

- Complete the firewall kinship form
- Complete Lexis Nexis search
- Contact relatives/kin identified through engagement of the family and during considered removal meetings. Staff must contact the child's parents and the child, if appropriate. Once the list of relatives/kin is completed, they must indicate the method they engaged the family (via phone call, visit to the home, etc.) and whether they are an option for placement. If no appropriate relatives/kin are identified they must indicate the reason.

This activity must be completed every time they are considering placement in non-relative foster home, if there is an emergency placement, or in non-emergency situations. For any non-relative/kin placement, the Kinship Firewall must be approved by the New Britain or Meriden Office Director. These approvals are then reviewed by the RA.

The regional fatherhood firewall and engagement protocol is intended for Intake staff to make reasonable efforts to identify all fathers during the initial contact with the family. This process begins at Careline and the screeners are to ask specific questions regarding the father(s) of children involved in the report. When the case is assigned to intake staff, the following activities occur:

- Intake/Family Assessment Response (FAR) SWS to assess father(s) involved with the family when the case is assigned and document the first SWS conference narrative in LINK indicating the plan to engage father(s).
- At around 20th day following commencement, all fathers should be identified. Intake SWS will discuss with Intake SW efforts made to identify and engage father including progress or barriers. If there is no progress made, the intake SWS and SW will develop an action plan to do so. This will documented in the second SWS conference narrative in LINK. At or around 40th day following commencement, ISWS to review the case for closure or transfer and review/update the action plan develop and follow up on progress or barriers identified. This will be documented in the third SWS conference narrative in LINK. The case cannot be closed or transferred without

documentation of efforts made to identify/engage fathers. Intake Manager will review case upon completion of assessment to determine if fathers were identified and engaged according to action plan. Cases cannot be closed or transferred with no plans or follow plans.

- Once case is transferred to Ongoing Services, the Program Manager will review plans where have not been identified or engaged and immediately identify follow up steps required by OSWS and OSW. This will be documented in Managerial Case Review narrative in LINK before assigning the case. OSWS will review the action plan with the assigned OSW and document it in LINK SWS conference narrative. Fatherhood engagement will be an ongoing discussion in supervision and documented in subsequent SWS conference narratives in LINK.
- Other resources that further support documented efforts to identify/engage fathers are: Principal attorney consultation; establishing paternity as quickly as possible (birth certificates, acknowledgement, etc.); ACR; Considered Removal Meetings and Permanency Teaming Meetings.

This process is monitored and ensured through the regional QI Intake Review process. Region 6 also has a FELT committee that works to further assist in fatherhood engagement and involvement of fathers with their children.

Permanency Implementation Team (PIT)

The Permanency Implementation Team meets monthly, alternating between New Britain and Meriden Offices. The PIT has been responsible for the implementation of permanency teaming within the two offices. As a result of this committee, the two offices have implemented ongoing permanency consults with the QA SW and Permanency Exchange Specialist (PES). THE QA SW and PES have done unit consults with each unit in the offices and do individual consults as requested/needed. The QA SW and PES actively follow-up on these consults to discuss progress on the cases and to ensure permanency practice is occurring and expanding region-wide. During the consults, the QA SW and PES are using the Lauren Frey model of consultation. The QA SW keeps a log of the cases where consults have occurred. This information is shared with The QA/QI PD, the RA and AODs. The QA SW and PES are also sitting in on OPPLA reviews every other week in each office. During the OPPLA reviews, anywhere from 2-5 cases are reviewed. These cases are also logged. The QA SW and PES make recommendations about individual cases or how to move permanency teaming forward.

The PIT has also created and implemented the Family Search and Engagement (FSE) Teams for each area office. The purpose of the team is to assist staff in finding extended kin and family members who can be a support or a connection to youth/families. The responsibilities of the team are case mining, cold calling and consultation and outreach that is appropriate to assist the CPS team in finding kin/connections for the youth. The FSE teams consist of CPS, QA, and FASU staff, and when appropriate, TFC providers. The referrals and activities are logged by the QA SW, including the number of cases that team has worked on and the services that the team has provided. The information in the log is provided to the QA/QI PD, the RA and AOD's. The information is also shared at the monthly PIT meetings with staff.

The PIT team is also currently working on two other projects that will be implemented in 2016. The first one is the Permanency Roundtables, which will encompass the current OPPLA case reviews. The

roundtable will consist of CPS staff, QA SW, the PES, other OPPLA team members such as FASU and Adolescent Staff, as well as outside providers to assist with the permanency planning. These cases will be logged and tracked by the QA SW. The second initiative is a Permanency Workshop Series, the content of which was chosen based on a confidential office wide survey and feedback from SWs and SWS during permanency consults. The goal of the workshops are to support and increase staff skills in the implementation of permanency teaming. The topics will include a mock Large Team Meeting, Conflict Resolution and the components of the permanency teaming process. This series will be offered in both the New Britain and Meriden offices to all staff.

There have also been various trainings held within the region to support the implementation of permanency teaming: 3-5-7 Model by IPP; Family Search and Engagement by Klingberg; and Adolescent Permanency Teaming by Klingberg. Attendance by staff are logged and reported to regional managers.

Quality Improvement Team (QIT)

The QIT Committee meets monthly to ensure the implementation of the region 6 exceptional case planning process. This committee designed the Region 6 Toolkit, which provides resource information and best practices to social work staff in writing complete and comprehensive case plans with their families and youth. The QIT has outlined ten strategies to improve case planning for Region 6 staff:

1. Staff will be trained on how to obtain, interpret and use the case practice report guide.
2. The QA SWs will provide leadership with qualitative OM3 and OM15 reports which will be given to all staff.
3. The Offices will increase the court monitor involvement. In Meriden, this will be done by having the court monitor come to the office every two weeks for case consultation.
4. Social workers struggling with case plans with be given individual support plans as needed.
5. PM's will provide monthly business reports in which they will report out on how many ACRI's have been reviewed by SWS as well as the themes in the ACRI's.
6. SWS will ensure the use of the toolkit by SW's.
7. PMs will complete one qualitative review per SWS each quarter, assess and provide feedback.
8. ACR staff and SWS will provide in home case reviews to staff to identify areas needing improvement.
9. QA Staff, PM's, SWS's, RRG staff and Systems Director will work to determine reasons why parents and children's needs are not being met appropriately.
10. RRG utilization will be increased.

Critical Incident Log/Reviews

A log of all critical incidents received in the region is maintained by the regional QA Manager. The log identifies which cases have been substantiated, closed/transferred, had supports, etc. Any case that has DCF history within a year of the critical incident is reviewed in its entirety. The objective of the case review is to identify areas needing improvement in case practice, service delivery and investigation. Upon the completion of each review, a learning forum is held with the OD, PM, SWS, SW and others, including central office staff.

OPPLA Reviews

OPPLA reviews are held annually for every youth with an approved plan of OPPLA. The objective of the review is to ensure that permanency team meetings are being held with the purpose of identifying natural supports to youth in care. Additionally, OPPLA reviews are held with the office director for every case prior to identifying a goal of OPPLA. Prior to approval, the office director is to ensure that concerted efforts are being made to identify relative and kin supports and also to ensure that all preferred permanency plans have been exhausted prior to the selection of OPPLA. A regional OPPLA log is maintained by the QA manager to ensure that these OPPLA reviews are timely, and to track concerted efforts/progress over time with these youth. The log drill down includes Office, Manager, SWS, SW, Case, Child, DOB, Placement, Lifelong Connections, PSE Status, Young Adult Programs, Date of Reviews and Decisions.

Icebreakers with FASU

The regional icebreaker process seeks to promote relationships between the biological and core foster homes that will lead to better outcomes (less disruptions) and permanency goals for the involved children. These meetings are scheduled and tracked by FASU staff and the Systems PD, and occur following placement and in accordance with permanency teaming guidelines. Barriers and problem areas are identified and shared at regional management meetings.

DCF In-Home Case Monitoring

All in home cases open 9 months and longer, no legal, low risk are assessed for case closure, including legal consultation as needed. This report is reviewed monthly to assess any new cases that arise. CPS Program Managers and Supervisors review these identified cases and assess for legal intervention or closure. QI Manager will track progress on these cases as needed, and RA reviews these cases on a monthly basis.

OM4 - Relative Resource Search

In order to ensure that all cases have relatives/kin/supports identified as part of case planning with families, tracking of searches is done on a monthly basis. Outlook reminders are provided for ROM reports regarding relative searches to ensure all cases have such a search with concerted efforts documented every six months during a child's placement. This search is also a part of the Permanency Teaming practice occurring regionally. The Kinship Firewall also helps to ensure that this search is completed prior to any non-relative/kin placement. Performance is monitored monthly by supervisors and managers, and reported out quarterly in the region's strategic plan.

OM16/17 – Visitation

In order to ensure visitation standards are met, LINK and ROM reports are reviewed monthly. Outlook reminders are done at mid-month utilizing ROM countdown reports to ensure all cases meeting standard prior to end of month deadline. CPS Program Managers and Supervisors are required to follow up with all staff where standard is not met to determine barriers and to provider support and interventions as needed. These results are aggregated each quarter and reflected in the Region 6 Strategic Operational Plan.

OM 22 – MDE

To ensure children will have a complete screening of their needs within their first month of placement. The process entails FASU sending the name of the child/youth placed to the Region 6 MDE coordinator who schedules this MDE with the caretaker and child/youth. CPS staff and RRG review the results and follow up with the recommendations. These results are used to shape the case planning for the involved families and youth. LINK and ROM reports are reviewed monthly by OD's and QA Manager to ensure standard is met and what, if any, barriers existed to prevent the MDE from being completed.

AWOL/Runaway Database:

To ensure an accurate count of youth who are AWOL or run away from DCF care and custody. An AWOL/Runaway database is maintained statewide and reviewed weekly by QA staff. Weekly reminders are sent to all regional staff to ensure that the log is updated with newly missing youth and those who have returned to DCF care and custody. This process also ensures that concerted efforts are made and documented in LINK records to locate and return these youth to their intended placement settings. This log is reviewed monthly by office directors and RA to ensure follow-up has occurred as needed.

NYTD Surveys

To support IV-E planning, an assessment of youth at ages 17, 19 and 21 is done regarding the results/outcomes of our youth who transition out of our care. These youth are identified by DCF CO staff and CPS Adolescent or QA staff complete the surveys, depending on whether the case is closed or not. The data is entered into Case the Planning Survey Icon, where CO is able to access and analyze this data.

IV-E/SSI Reimbursement

Completion of all IV-E/SSI/SSDI applications and reviews by the Social Work Liaison to ensure appropriate benefits are connected and follow the child/youth as appropriate. The QA Social Work Liaison initiates the application process, gathers the required information, and supports the social worker in connecting the benefits to the child/youth. This information is tracked by the liaison in a regional Excel database.

CARELINE RECURRENT and DEVELOPING QA/QI ACTIVITIES

QA Process:
The Careline is dedicated to developing and implementing a robust quality assurance plan, through the use of a Critical Service Review Protocol (CSRP) process that includes:

- Review of new allegations of abuse or neglect on open cases, for both CPS and FAR involving children 0-3 (all household members) at the Careline level.
- Response protocol specific to all reports involving children ages 0-3
- Review of the Non- Accept aggregate data in order to identify strengths and problem areas
- A quarterly multidisciplinary peer-review process consisting of Careline, Workforce Development Academy, Program Review & Licensing & Regional Management.

FAR Report Review Process:
This change comes in part to our continued effort to standardize our practice of decision making, coupled with the high risk attributed to this age population. As an agency we are conducting an assessment of all of our practice(s), as it relates to this age group who appear to be our most significant challenge as an agency.

As of July 1st 2015, Careline social work screener are required to forward on any reports where a FAR designation involving a child(ren) age(s) 0-3, to your supervisor for review and appropriateness.

A quarterly FAR audit will be conducted by management, assessing 25% of a month's worth of reports. Utilizing the following questions as guidance:

- *Were the rule outs used correctly?*
- *How many of these that were identified as FAR had SA involvement?*
- *Was there significant history? **3 reports (FAR or Intakes) or more..***
- *How many previous FAR's were associated with these cases?*
- *Was there any discussion held with the SWS?*
- *Of these FAR reports, how many had elements of DV/IPV with them?*

Accepted Report Review Process: (Ongoing quarterly)
In December 2014, the management team at the Careline participated in a qualitative review exercise of all accepted reports that were disseminated to the Area Office's for investigation, which named the "Accepted Reports Pilot". The decision to review accepted reports that have been assigned for investigation was in part our desire to review the quality and appropriateness of the reports being generated. From those reviews, we would then be able to extrapolate useful data and trends that may have meaningful effect towards our future practice in the specialized area.

o Quarterly, Careline management will be pulling one (1) report from each supervisor across all shifts on a daily basis over any consecutive two week period.

o Managers will then contact Area Office Investigations Supervisor's (in instances of concern regarding a report) to discuss the following, regarding the reports selected:

· *Did we get the necessary information needed for them to start a solid investigation?*

· *What else could they have used in the report?*

· *Things we did well?*

· *Things we need to be mindful of?*

Written feedback will then be provided to the social work screener by the SWS during supervision

Non-Accept Review Process:

Non- Accept Practice: In situations in which the Area Office may have information that merits a reconsideration of a Careline decision to accept or not accept a report, the Area Office shall request a change of the decision.

Drawing from recent and tragic case examples where a report was not accepted, it was imperative to review and assess our current practices related to the 0-3 population. The process will be as follows:

A monthly multidisciplinary peer review process of non-accepts will include but not be limited to the on average of 20,000+ annual designated reports.

A monthly/quarterly audit, consisting of 20% of the non-accept data report, involving children ages 0-3 will be disseminated to the multidisciplinary panel consisting of Careline Management, Workforce Development Academy & Program Review & Licensing.

Observations, trends and data will be catalogued and tracked by the Careline. This information will be provided to Careline staff for the purpose of guiding and improving practice during the course for supervision.

Observations, trends and data will be catalogued and tracked by the Careline and provided to senior administration and ORE for consideration.

OFFICE OF ADMINSTRATIVE CASE REVEW RECURRENT and DEVELOPING QA/QI ACTIVITIES

Pursuant to Federal legislation, states are required to engage in case level quality assurance activities. Under Public Law (PL) 96-272, the Adoption Assistance and Child Welfare Act of 1980, strengthened by PL 105-89, the Adoption and Safe Families Act (ASFA) of 1997, which mandates that each state design and implement a case review system, which has five areas that apply to all children in foster care:

- provide for a written case plan;
- provide for periodic review;
- assure that the state has a permanency hearing;
- provide a process for termination of parental rights proceeding; and
- provide notice of and an opportunity to be heard.

As a means to assess and ensure not only compliance with the above law, values and practice vision, but to facilitate sustainable, positive outcomes for children, youth and their families, the Department engages in such reviews through its Office of Administrative Case Review (OACR). This office is a statewide operational unit responsible for the Administrative Case Review (ACR) process/system within the six (6) regions of the Department. The OACR Leadership includes a Program Director and four (4) Program Managers who supervise fifty-two (52) ACR Social Work Supervisors (SWS) across the regions. There are also three (3) ACR Continuous Quality Improvement (CQI) SWS at Central Office who report to the OACR Director.

The Department views the administrative case review function simultaneously as a quality assurance and quality improvement activity. To this end, the OACR has created a CQI plan which serves to demonstrate and guide the Department's commitment to not only ensuring that the care, case planning, and treatment needs of the children and families that it serves are met, but that DCF has a reliable mechanism to comprehensively and proactively assess the quality and effectiveness of its child welfare practice and its broader service delivery system. The following are some of the recurrent quality assurance/improvement activities that are occurring as well as some that are slated to launch in early 2016.

OACR Monthly Workflow

On a monthly basis, each OACR Program Manager submits a workflow log for each office within his/her region(s). This worksheet currently exists in Excel and was developed in August 2015 as a mechanism to compile various data points that are not currently available in any one report for each OACR supervisor. At the end of each month, OACR supervisors enter information into the log to capture their flow of work. Information that is recorded includes: the number of pending ACRIs at the beginning of the month, the number of ACR meetings held and the number that require an ACRI to be completed during the month, the number of ACRIs completed during the month and the number remaining again at the end of the month. This workflow also captures the number of work days in the month and the number worked by each OACR SWS. Ideally this type of report will be developed as a dashboard, but because it was just created and implemented in the last four months, the OACR management is still assessing the need for modifications. On a monthly basis, these workflows are compiled onto a single spreadsheet and analyzed by management to assess equitability in ACR volume across reviewers, and number of days worked is factored into this review as well as whether or not staff are full or part-time. Management also reviews the data alongside the completion reports in LINK to see on a monthly basis, what is the range across reviewers with regard to how many ACRIs they are able to complete. The information from these reports help management to assess capacity across the state and to identify in advance areas needing focus, specifically with regard to the volume of reviews and equitability statewide. The data is also critical in that it provides management statewide perspective as to what the reasonable standard is for the completion of ACRIs and highlights performance trends. The OACR Program Managers e-mail their

data monthly, in Excel, and this is on file with the Director of OACR. At this time, there remains some education needed with OACR staff around completing the logs accurately and again, this is data that continues to be collected monthly in anticipation of developing an automated dashboard, however, it remains an important tool.

Inter-Rater Reliability Exercises

Monthly inter-rater reliability exercises are conducted with all OACR staff as part of the staff meeting. Managers communicate with each other and identify a scenario to present to all staff for review and rating. During the meeting, reviewers are provided with a document that includes the relevant scenario details as well as the specific element they are to be rating. Each reviewer works independently to review the information and document their rating and summary statement on the form. Reviewers are not asked to include their names, but are asked to identify the office in which they are employed. Managers collect the responses and review these to assess for consistency in ratings, clarity in summary statements and appropriateness of the standard being applied. The ratings are then calculated and themes related to rationales for ratings are summarized. The findings are graphed and presented at the following staff meeting in a Power Point, and the preferred rating and rationale are also discussed. Prior to the presentation at the next staff meeting, managers each receive the completed IRR activity forms for their regions and use this as part of their supervision. The purpose in reviewing this data is to assess consistency in ratings across reviewers so that we can insure consistent feedback to regional staff with regard to practice, standards and outcomes. Each IRR activity and related findings are currently tracked in Excel, however, the OACR is in the process of overhauling the SharePoint site and will ultimately move the IRR data to that site. The management team is also working on a protocol which includes revisiting prior IRR scenarios to assess if there is an improvement in IRR since the initial activity. This remains under discussion as this process has also been initiated in the recent months.

Monthly ACRI Reviews by OACR Program Managers

OACR Program Managers conduct monthly ACRI reviews, however, this process has not been sufficiently formalized. The OACR is slated to launch a standardized protocol for ACRI reviews in the coming months which will also detail the number to be reviewed on a monthly basis. It is proposed that the OACR managers identify elements within the ACRI for review, based on those elements known to pose the most challenging across reviewers, or those elements for which there has been either a change in guidance or policy. The Case Practice Report by Reviewer also provides quantitative data related to ratings and variation across reviewers for each indicator and is used by the managers to identify areas for targeted qualitative review. As managers review the ACRIs, each section will be reviewed for accuracy and any discrepancies or errors will be logged according to themes. Currently there is no identified mechanism for logging this information and while there were discussions about Excel, given the work being done on SharePoint, the management team will discuss alternatives to Excel for tracking the data. Some of the data to be gathered includes whether or not staff adhered to standardized formatting within the ACRI summaries, accuracy of the rating given the information presented and the adequacy of the rationale in explaining the rating. The findings from the reviews will continue to inform the IRR activities with staff and will provide management with feedback for staff to correct any areas needing improvement, which will ultimately improve IRR across reviewers. Findings will also highlight areas within the ACRI guide where guidance needs to be clarified or changed.

OACR Practice Reviews

Practice reviews are conducted on a quarterly basis and focus on a particular practice that often has a connection to both OACR and CPS making this an opportunity for shared learning. Examples of these reviews include: Safe Sleep, Use of N/A, Case Practice Assessment, and Rescheduled ACRs. OACR management identifies an area for review, typically as a result of either new policy/guidance having been issued or data changes in the LINK reports that highlight a potential issue, and a timeframe for review is identified. A random sample of ACRIs within a specific period of time are selected and the review is conducted by the ACR Program Managers utilizing a tool developed in Excel for that specific review. The sample size is dependent on the specific practice being reviewed and the approximate time each review will take and the capacity for managers to complete these reviews in the identified timeframe. Data related to these reviews has been collected in Excel, but this is not idea and is an area the OACR management team is working to refine and enhance. Following completion of the data entry and ACRI reviews, the data is reviewed to identify patterns/trends

with the OACR SWS in their documentation, application of the standards or overall ratings as well as to highlight patterns/trends with regard to the CPS practice. The data and summary report are shared with OACR staff in all-staff meetings as a mechanism for improving inter-rater reliability and as an opportunity for staff to seek clarification. OACR managers each share the practice review findings with their regional leadership teams and following a review in which there are specific findings related to CPS practice, the Director of OACR also issues a memo to agency leadership that summarizes the review and findings.

As a new initiative within the OACR, the practice reviews continue to be developed. It is anticipated that there will be a formalized outline of quarterly practice reviews to be conducted by the OACR in early 2016 which will include a review of visitation on in-home family cases.

OACR LINK Reports

Recognizing that the work of the OACR must be informed, guided and driven by data, the management team routinely reviews and analyzes the OACR LINK reports to inform leadership about both the practice within the OACR division as well as the trends in practice across offices and/or regions. The periodicity of the reviews varies by report as detailed below. While the LINK reports provide quantitative data, the OACR managers utilize these reports as a platform for qualitative reviews, taking a closer look at practice where the data highlights an increased need. The below are some examples of these reviews:

Case Practice Report: This report identifies areas of strength and areas needing improvement for key practice indicators that are assessed as part of the ACR for each case participant. The OACR managers review these reports, sorted by region and office, on a monthly basis and provide feedback to Regional Management teams about the trends and patterns related to case practice. The universe includes all ACRs that were held during the specified period of time, for which an ACRI has been completed by the time of the report run. The data is housed in LINK, but is used to inform Area Office/Region leadership about case practice that is recent, but is also used to look at practice trends over time and is then reviewed in the context of the region's Strategic Plan. Managers typically provide these reports during regional leadership teams and they are also discussed in OACR Management meetings. The reports are used in area office strategic planning meetings and are often shared as part of the quarterly Regional Strategic Planning Presentations to the Commissioner's Team. As leadership continues to review and discuss the Case Practice Report data, decisions are made with regard to strategic interventions (continue with the interventions, or implement a new intervention).

ACRIs Not Completed in 15 Days (overdue): Bi-weekly reviews of this LINK report are intended to provide data related to the timeliness of ACRI completion. These reports are now accessible to all DCF staff, but are primarily utilized by the OACR managers as a tool to assist in managing the workflow and in cases in which completion is not timely, managers are able to then work with staff to insure CPS staff have received the necessary feedback related to their case plan while the ACRI remains pending. The universe for this report includes any ACRI that has not yet been completed for an ACR that was held more than fifteen days prior. When pulled, this report lists all of the overdue/pending ACRIs, however, managers then export the data so that it can be manipulated in a way that shows overdues by OACR supervisors as well as the office associated with those overdue ACRIs.

Scheduled ACR Report/OA Meetings: Each month this report is reviewed by the managers to insure equitable distribution of ACRs amongst reviewers across the state for the upcoming month and to insure that reviews are being scheduled timely. This information is obtained from an ACCESS database which pulls from LINK data. The data is used not only to equalize the workload, but to also assess OACR capacity and needs in each of the offices. Reports are disseminated and discussed in OACR management meetings as well as in quarterly OACR Office Assistant (OA) meetings where the importance of timely scheduling is reinforced. This report has been used to identify recurrent scheduling issues in certain offices and has led to the reinstitution of the quarterly OACR Office Assistant meeting. Office assistants schedule reviews and balance the ACR schedule, however, there are differences in their processes and practice variance over time has increased. The desired outcome through these meetings is to achieve consistency in scheduling protocols and related practices that support meaningful ACRs. Data reviewed during meetings includes

meetings held after the proposed date, timeliness of letters and rescheduled meetings. The data is pulled from LINK reports and is not housed in a separate database.

OACR Advisory Council

The OACR Advisory Council meets on a monthly basis at the Court Monitor's Office in Wallingford and is comprised of one ACR SWS from each region, all of the OACR management and the three ACR CQI SWS from Central Office. This group serves in an advisory capacity and is the venue for vetting new proposals or practice guidance. The Advisory Council has been instrumental in bringing issues to the attention of management, based on feedback from their peers and/or area office staff. The council members have also taken leadership roles within the OACR and serve as co-leads on various projects including: ACRI enhancements, SharePoint overhaul, OACR brochure/informational cards and the redesign of the supervision model to meet the needs of administrative staff such as OACR SWS. This meeting is facilitated by the OACR Director, meetings are drafted and council members are responsible for sharing the information with their regional peers. Additionally, these staff are now allotted time at each staff meeting to provide updates on their activities to all-staff and can answer questions that arise. Minutes from meetings are currently with the Director, however, it is intended that these be posted on SharePoint once the site has been redesigned and made current. Results from any ACRI reviews are shared and presented to the Council in advance of the all-staff meeting to gather feedback so that any necessary changes can be made. Information from these meetings continue to be used to improve existing documents/tools for OACR and to develop tools that have been identified as needed. The feedback from the council and connection between them and all OACR staff is designed to insure continuous feedback and improvements throughout the system.

OFFICE OF CHILDREN and YOUTH IN PLACEMENT RECURRENT and DEVELOPING QA/QI ACTIVITIES

Therapeutic Foster Care. TFC and FACT providers enter client level data into PSDCRS/PIE for each admission and discharge into their program. Data is reviewed by the TFC PDOC on a quarterly basis and the data helps inform the RBA outcomes as identified in the programs' Scope of Service. Reasons for Discharge and Episode Count and Length of Stay are two primary reports reviewed at minimum, on a quarterly basis. Discharge data is used to look at permanency outcomes (i.e. adoption, reunification, placement with kin), discharges to higher levels of care, and disruptions to other foster homes.

Providers also submit monthly stats via an Administrative Data portal which is exported into excel so that stats can be collected and disseminated on a monthly basis and submitted to the Court Monitor's Office quarterly. This data is foster home level data and includes elements such as net gain/loss, number of available homes, homes on hold, and respite data. Information Systems is in the process of making changes to the system to add the capability to collect the same data for FACT as TFC, as well as Kinship placements in both TFC and FACT homes.

LINK Reports is used regularly to review DCF's internal data as relates to number of children in TFC, FACT, and other service types. Data is sorted by region, provider, type of placement, time in care, and demographics such as race, ethnicity, sex, age, and legal permanency goal.

In July 2015, a SharePoint site was developed to capture all TFC referral data. The TFC liaisons in each region are responsible for entering referrals into the system. The data is exported into excel and can be analyzed per provider, region, emergency vs. non-emergency, placement at time of referral, date of match/placement, race, etc.

The TFC unit at Central Office is also responsible to license and reapprove approximately 800 TFC and FACT families annually. Review of licensing documents such as background checks are monitored prior to the provider being entered into LINK. Risk Management reports such as Significant Events and Critical Incidents are reviewed daily, and provider follow up is made on an as needed basis. All non-accepted and accepted referrals to the Careline are reviewed and forwarded to the program director at the appropriate agency along with the assigned DCF regional and/or SIU designee. A database is maintained to track outcomes and Assessments of Regulatory Compliance (ARC) documents. Homes with open investigations are placed on hold and ARCS are entered into Provider LINK narratives.

TFC and FACT data is shared with providers regularly at site visits, Statewide Meetings, Community of Practice meetings and TFC/Regional network meetings. RBA updates are provided on a quarterly basis at the executive team's SARA meetings to report out on trends related to programmatic growth and areas in need of improvement.

Congregate Care. Residential Treatment Centers, Therapeutic Group Homes, SFIT and STAR homes all enter data into the PIE data collection system. PASS, SWETP and maternity homes provide data to us on a quarterly basis. This data is maintained by the congregate care staff at CO. In addition to these data collection systems all congregate care scopes of service have been updated to the new Results Based Accountability (RBA) system, and report cards have been completed or are in process on all service types. Data is also gathered from Risk Management and ORE and reviewed

on a quarterly basis. Value Options collects data in areas including hospitalizations, individual and group treatment hours and one to one requests.

Data is analyzed by the PDOC and RBA report cards are compiled. Report cards and reports on Risk Management data (arrests, AWOL's and other data) are shared with providers and discussed in bi-monthly statewide meetings. Data is also shared with individual programs when the need arises and discussed with local entities when concerns are raised regarding a program.

Periodic site visits are also conducted and during those visits case record reviews and interviews occur to assess areas such as life skills attainment and family engagement.

The new TIER classification system will begin quality assurance activities on the STAR and SWETP programs beginning in 2016. This will provide an additional layer of quality assurance oversight and reporting.

Licensing conducts quarterly site visits and conducts physical plant inspections and case record reviews. This information is shared with the Office of Children and Youth in Placement, which oversees congregate care and the PDOC for congregate care works closely with licensing when programmatic concerns arise.

Adoption and Subsidy. An adoption Log is maintained ongoingly for all cases sent to CO for adoption approval. It assists in providing monthly stats, monitor patterns and provide oversight of workflow. The log is completed monthly and records how many, rates, fiscal commitments for addendums and basic information

The Adoption Unit developed and implemented a pre-adoptive triage process for all cases with proposed complex adoptive addendums. Each Triage process builds a child's specific team to include the assigned CPS staff, RRG staff, Health Advocate, providers when appropriate, Central Office Health Advocate, fiscal staff and the adoption unit staff to negotiate and develop together an appropriate adoptive addendum. The triage process streamlines the negotiation process, pulls in CPS/CO staff with professionals to fully access all the services needed to support an adopted child, remain fiscally and legally responsible and maximize the use of insurance benefits whenever possible. Triage occurs on a weekly basis for each case requiring a Triage Meeting. As of 1/1/2016, the triage numbers will be tracked with a plan to monitor for patterns of unmet needs and a plan to work with the Health Advocates to address.

The Adoption 800 process was implemented November 2015 for all denied addendum modification requests. An 800 is sent out for each adoption denial of addendum modification requests which will confer upon families their due process notification and the ability to request a hearing to protect their rights. Adoption Denial 800's are generally disseminated once or twice a month. Starting 1/1/16, the denials and the requests for hearings will be logged in an effort to track patterns and address barriers related to adoptions.

STOG 800 process implemented November 2015 for all noncompliant bi-annual 418 reviews. STOG 800's are sent out for all non-compliance bi-annual 418 reviews to increase program compliance, to remain fiscally compliant with the agency program and to reinforce agency expectations. Approximately ten 800's for STOG non-compliance for annual review are sent out monthly. Specific Case Data has been collected for issued 800's for noncompliance for the months of October 2015 and November 2015 and reviewed by PM for patterns.

The STOG log is maintained ongoingly for all cases sent to CO for STOG Approval. The STOG Log assists in providing monthly stats, monitor patterns and provides oversights of workflow. It is completed monthly. Stating 1/1/16, the STOG Log data will be totaled monthly and monitored for patterns.

STOG quarterly audit for youth over age 18 initiated September 2015. STOG quarterly audit for youth of 18 will reduce overpayments to a current system that is manually handled at this time. If overpayment has occurred, the overpayment protocol will be put in place (letters sent regular and certified, calls will be made, an effort will be made to engage the family into developing a repayment plan and if this is unsuccessful the unit will involve fiscal and a DAS collections referral.) STOG Audit completed quarterly. Audit Cases are reviewed to see if any case has gone past the programs age guidelines, any case nearing that date will be targeted for a date to be closed. If any case is to go over that date, then the overpayment protocol will be put in place.

The Family Registration log is maintained ongoing for data for all families waiting, teamed and on hold and those with a placement. The Families Waiting Log provides information on the different types of families available for anticipated matches and the ongoing data provides information on which office request matches and what type of matches are being requested. The data reflects the agencies specific needs for families. The Families Waiting Log is updated monthly and is used to collect data on the types of families who are waiting for a match for an adoption child and what type of child or how many children they would be interested in having placed in their home.

The Permanency Exchange Specialists maintain a log monitor their regional responsibilities. These logs assist in providing monthly stats, monitor patterns and provide oversight of workflow. They are updated monthly. The PES Log outlines and monitors the different tasks, types of permanency cases that require PES assistance, number of youth they are working with to move along to permanency and what types of specific task of training or coaching they are providing in the region.

A search log is maintained to monitor all requests for all the types of searches. This log assists in providing monthly stats, monitoring patterns and providing oversight of workflow. The search log is updated monthly and monitors frequency and types of requests that the department receives.

Reviews of these logs are done to monitor for patterns, noncompliance, follow up and to implement changes in practice as needed.

Data, Logs and stats from the logs are reviewed monthly for stat numbers (how many opened/closed), reviewed for patterns of unmet needs, reviewed to identify work flow patterns/barriers and reviewed to identify changes in practice needs.

Monthly stats are sent to PD, Quarterly stats sent to PD, stats shared in joint meetings with PM and SWS, stats shared in the monthly team meetings and when appropriate stats shared in the statewide quarterly managers meetings.

When data is collected and shared in any of the group sessions for discussions with the team staff meetings, statewide permanency manager meetings, AAP quarterly meetings and PPSP monthly meetings, an opportunity is always provided for feedback and next steps to improve practice. Often there will be follow up mini groups developed to continue to review a particular pattern that has become apparent during this process that may require a more involved approach.

Interstate Compact Office. Data is collected ongoingly and captured on an Excel spreadsheet that is stored in SharePoint. Data can be analyzed to identify trends in requests and outcomes achieved. This includes around numbers of requests, numbers of children placed out of state, race and ethnicity and time to process the request (submission to placement). Systems are in place to monitor time frames for completion and generate reminders to other stakeholders to support timeliness. Data is shared internally and externally with other participating ICPC States. Information shared between states has been used to improve the Interstate process as well as revise Articles and Regulations.

LINK is also accessed to obtain data to cross reference and confirm placement dates and time frames and in some instances duration of placement. LINK is also reviewed to discern child's placement history within and outside of Connecticut and to track case and placement status by reading the ICO-CSC and AO staff narratives.

For **CHAP and CHEER and Credentialed Case Management** data is submitted via an Excel spread sheet once a month. Providers submit this information to the PDOC and the PDOC houses it in an email folder and on an s-drive. Fiscal has data from LINK payments as well. Data is reviewed and discussed at monthly provider meetings. Reports are reviewed with providers monthly. Data is used to ensure the program is meeting needs of clients we serve. There are nine credentialed providers.

With **Community Based Life Skills (CBLS)** data is submitted once a month. There are quarterly meetings and quarterly and annual reports submitted to the PDOC. Data is collected in an excel spreadsheet with demographic and program information including assessment data, number of youth served, and client satisfaction. Data is kept on the PDOC's s-drive. Quarterly data is compiled into a master spreadsheet. Hard copies of information are distributed to the providers at their meeting. Data is used to inform progress and to influence practice. Data is used to help enhance the agency's ability to meet client needs. There are 10 provider agencies.

For the **High Risk Infant program** monthly data is collected in a table and submitted to the PDOC. There is one contracted provider who reports on how many clients are served, and if the women are benefiting from educational classes. There is a master data sheet on the PDOC's s drive. Hard copies are reviewed at monthly meetings. Monthly meetings are designed to help ensure that a program is meeting contractual requirements.

Beginning in January, 2016, the **Learning Inventory Skills Training (LIST)** QA will involve collecting data on SharePoint and from PIE (If PIE is not ready, excel spreadsheets will be submitted from providers and stored on the PDOC's s-drive). Quarterly and annual summaries will be collected. The LIST is required for youth over age 14 who are committed to us and in out of home care. It is recommended for youth committed delinquent. Information collected will show the number of youth getting a service, domains completed, when the assessments are due, etc. Data will be used to determine who is receiving the services and if youth are better off and prepared for success in multiple venues. Congregate care providers and TFC providers meet every other month in statewide meetings. Other providers have quarterly meetings.

With our **Multidisciplinary Teams and Child Advocacy Teams (MDTs and CACs)** case data is submitted via NCA Track. Client and Team satisfaction surveys are also collected. Team evaluations are conducted every 3 years. The team evaluation reports requires a written response, action plan and a 6-month and 18 month review. The Village houses team evaluations. Case related data is collected including client specific information, perpetrator specific data, medical information, etc. The CT Children's Alliance compiles statewide reports and shares with membership, the PDOC and

the Governor's Task Force. There are 17 MDTs. These identify low case referrals, client and team concerns that need to be addressed.

In our One to One mentoring work the PDOC has monthly and quarterly meetings with providers. There are 12 provider agencies. Providers complete an excel spreadsheet. LINK pre fills quarterly reports and annual data. This tracks client contact, demographic, gender, race, and ethnicity. Hard copies are shared at monthly meetings with providers. Mentoring data is shared with the provider to address program needs. General data is shared with the provider. There are annual site visits and annual summaries.

Work to Learn. Monthly data from providers is entered into PIE. Monthly data entry and quarterly RBA report cards will be prepared. Providers enters data and the PDOC pulls data from PIE. There are four contracted providers covering the state. Data is reviewed at quarterly provider meetings. Data is used to ensure contract compliance and ensure that youth are better prepared for transition to work and/or PSE.

Summer Youth Employment. Data is collected annually. The Department of Labor is the lead. DOL sends report data including race, ethnicity, gender, and age of participants, and program completion. DOL sends a year end summer report. There are five state workforce development boards that subcontract with various agencies and serve youth service bureaus. Data is housed on the PDOC s drive and in email folders. This data is reviewed with the Workforce Development Boards at the planning meetings at the end of the year as well as a statewide meeting.

CLINICAL and COMMUNITY CONSULTATION SUPPORT DIVISION RECURRENT and DEVELOPING QA/QI ACTIVITIES

Many of the service types included in the Divisions book of business have been established in PIE. However, there are a range of activities that occur outside of PIE given changes to program design, new knowledge that informs different data collection interests (i.e.: racial justice, reasons for discharge, treatment needs met). QA activities are conducted by every member of the team as the Division is made up on Program Development and Oversight Coordinators and many of the PD's fill those roles as well in addition to serving as Principal Investigators on Federal Grants.

For those programs included in PIE, providers enter client level data for each admission and discharge. Data is reviewed by the assigned PDOC on a quarterly basis. Detailed quarterly reports are prepared, analyzed and reviewed with providers and regional staff. In addition, the quarterly data informs the development of quarterly report cards submitted for periodic review at SARA. Among the key elements captured and reviewed are: # of clients' services, # of episodes, reasons for discharge and treatment goals met. In addition, race and ethnicity both in terms of referrals and outcomes are now being added to all reports to better understand issues of disparity and disproportionality.

Members also work closely with the regional gatekeepers, Systems PD's, licensing and fiscal to assure accurate and ongoing review at both local and statewide levels.

Interagency Client Planning: There are two databases developed to track and monitor the agency's responsibility around referrals and successful transfers to DMHAS and DDS. DMHAS referrals are centralized while DDS referrals are not.

The ACCESS database used for DMHAS and DDS tracking was originally designed in response to the need for a more formal system to monitor compliance with Outcome Measure 21. It continues to be an efficient way to assure that DCF has a systematic process for screening youth for referrals to DMHAS and DDS, tracking completion of referrals and providing feedback via monthly reports to the Regions and Central Office regarding status of these referrals, due dates and when referrals are past due.

With regards to DMHAS specifically, as the database has been updated, it has become a critical tool serving a number of other functions. Reports generated can be used by the DCF Regions, Central Office and by DMHAS to assure the agencies have a common list around which to coordinate eligibility, referral disposition, and follow-up on denials and to assure effective and timely transition. The DMHAS section of the database includes the following: current age, Area Office, LINK person and case ID's, current legal status, current residence (as well as residence at the time of referral), referral diagnosis, SSI status and dates of referral, eligibility determination and transition to DMHAS. Multiple reports are available from

this database for Regional and Central Office use and also provided to DMHAS to assist with both case specific, Regional and system-wide planning.

For DDS, the database is the vehicle through which DCF and DDS maintain a shared client list. The database elements include current age, Area Office, LINK person and case ID's, legal status, current residence (as well as residence at the time of screening), SSI status, DDS disposition and identification number, the DDS Region and their intellectual disability designation. There is a separate section in the database to track referrals to the DDS Autism division. All of this information is available in report format to the Regions and DDS and used in quarterly meetings to assure youth are identified for referral and transition to DDS.

For USE, the database collects demographic, clinical, and plan specific data (e.g., services, expenditures, provider, length of plan, etc.). All plans and waivers are linked to the specific client records for easy review and retrieval. The database supports the following activities:

1) Tracks all USE plans state wide that are both active and closed with estimated expenditures. (tracks anticipated spending). Report sent to AO's bi weekly and monthly.
2) Tracks when a USE plan is needed for a review and when a plan is past due for a review (various intervals occur depending on the plans structure (e.g., 30 day, 60 day, 90 day reviews are assigned to each plan). The review ensures that the AO is monitoring the plan for efficacy and when plans are to be closed to prevent continuous unapproved billing. Plans that are not reviewed will close after they are 28 days past their review date. Report for reviews goes out statewide every month.
3) Tracks provider satisfaction as reported by the SW. (report as needed)
4) Tracks provider need by region. The USE database is used to track trends in service requests. E.g., TSS is the highest requested service statewide. Identified need for behavioral services to be carved out, identified inconsistent rates for services throughout the state, etc.
5) Tracks demographic and clinical data. Used to identify trends. For example ASD voluntary youth were a large portion of USE expenditures in FY 15. (report as needed)
6) Tracks AO spending for youth where WRAP expenditures are over $5,000 and they do not currently have USE plans. A report is sent out monthly to the region by client so the AO can identify if a plan is needed for these youth.
7) Tracks plan goals and objectives. (a report has not requested at this time).
8) Has self-contained note system for each client with a USE plan for follow-up and tracking important information related to a plan (for example an exception was made when approving a service and why). Notes are used weekly by USE team as needed.
9) Weekly reports are sent to fiscal for payment coordination (if a USE code/bill is sent in by the AO, it is only paid if it has a matching active use plan).
10) Recently the USE team connected with adoption services to review USE plans and USE plan procedures for subsidy requests that refer to USE plans.
11) Saves money by instructing AOs to use insurance and credential/contracted services before spending WRAP funds and having AO check if TFC is paying anything out of their TFC WRAP and add it to the USE plans. It was found that some of the TFC providers were not using this money for clients with USE plans.

Community Support Services:
Monthly monitoring and review of data from various community based services is among the ways in which the PDOC is overseeing programs. This is coupled with the development of detailed quarterly reports and RBA report cards. In addition, the new TIER classification system will begin quality assurance activities on the OPCC programs beginning in 2016.

This Office is also responsible for managing and overseeing the CONCEPT federal grant requiring ongoing discussions with the federal project officers and semi-annual and annual reports tracking key deliverables. In addition, this Office oversees the implementation of evidence based models working closely with model developers to track model fidelity and outcomes. This includes the model developer for CBITS, CFTSI at Yale, MATCH – ADTC at Harvard and most recently through the newly developed Evidence Based Tracker Database developed in partnership between DCF, KJMB and CHDI.

Child Welfare, Early and Middle Childhood:
We have the benefit of strong partnerships with outside entities with respect to various service types that has been valuable in further informing practice and assuring an impartial lens to examine practice. An example of this is the Departments agreement with UCONN SSW with respect to Community Support for Families (CSF), which has seen expansion from only those cases referred to the CSF to all FAR cases and moving towards an examination of all Intake Cases in partnership with ORE to allow a review of the entire practice rather than a review in a vacuum. This partnership has allowed a deeper dive into #'s served, geography, disposition, prior and subsequent referrals, services identified and delivered, where referrals are coming from, race/ethnicity of families, etc. Data is shared quarterly and each year a statewide meeting is convened and facilitated to share the larger scope of data and allow time for regional breakouts. In addition a qualitative case review was conducted and another being planned. Cumulatively, these efforts have resulted in revisions to the policy and practice guide and enhancements in practice.

For those programs not developed in PIE – and to some extent those that are – further analysis is needed. As our practice and service array has expanded and been enhanced, there are recommended adjustments to what is currently being collected. In addition, some of the programs in PIE are also captured in other databases based on our agreement and expectations associated with evidence based practice models. For example, Child First has created a sophisticated data collection process and the PDOC then cross walks that with the data in PIE. For newer programs that have not been created in PIE such as RTFT, data is being collected by the regional gatekeepers and the providers and the PDOC is then pulling all data together to provide a statewide analysis of a complicated service type which contains

three service types within one scope. Another program not created in PIE is ECCP through ABH. Through this partnership along with a research project with Yale, ABH collects a great deal of data that is reviewed and analyzed quarterly and reviewed with the provider. This data has garnered both state and national attention as a promising practice model to build capacity of early educators, parents and result in very young children particularly with externalizing behavior to experience greater success in school.

PDOC's generate quarterly reports for all service types and meet with providers and regional staff on a quarterly basis to review and discuss findings to assure appropriate capacity and utilization, adjustments to improve outcomes, examine length of stay, etc. For example, recent data from the CSF program indicates average length of stay is 4 months but outcomes data clearly demonstrates better outcomes for those who experience a longer length of stay i.e.: 6 months as noted in the scope. As such the discussions with providers and regional partners is to refocus on length of stay data, what it's telling us and how to make necessary adjustments to yield better outcomes.

Also, similar to the notation in the Community Support Services section – federal grants are also part of this body of work and as such the PI is in regular contact with the respective federal project officers and submits semi-annual and annual reports regarding the specific deliverables.

Community Mental Health Services:

Due to a strong partnership that includes DCF, CHDI and United Way, the data reports on EMPS are extremely comprehensive and issued on a quarterly and annual basis. This year as DCF was able to provide some expansion to EMPS, it was this robust data set and our work with CHDI that informed the development of a sophisticated algorithm to guide the decision making process with respect to funding allocation. The reports are publicly available on the EMPS website.

In addition, the Department receives support through the Mental Health Block Grant. With that is a regular expectation to submit reports with respect to key deliverables. Some of the service types are captured in PIE while others are not. Whether in PIE or not, we expect the submission of key metrics depending on the service type and the development of report cards to answer the questions of how much, how well and if anyone is better off. Monthly and quarterly reporting inform discussions with providers relative to referrals, outreach, utilization and outcomes. The newest service type in this portfolio is the Care Management Entity that has both a direct service and administrative component and is funded through state and federal dollars. As such, there are a number of data and reporting expectations including client specific data as well as system level data that is managed through Beacon Health Options, the CME provider.

Substance Use and Intimate Partner Violence:

As mentioned previously, the Department has made a significant investment in evidence based practice models and as such central to such implementation is a robust QA plan prescribed by the model developers to assure model fidelity. As a result, PDOC's are responsible for cross-walking data that is collected and analyzed by model developers with data that is also captured in PIE. Examples of these include: Child First, MST and its adaptations and MDFT. In addition, through our partnership with ABH, data from RSVP and RCM is analyzed monthly and discussed with the provider. Data sits with various entities depending on the service type but include; MST Institute, ABH, Yale and the GAIN ABS.

Centralized Medication Consent Unit (CMCU):

The CMCU, is responsible for reviewing all requests for psychotropic medication use by a child or youth who is committed to DCF. A SharePoint site was developed to track all requests and assure compliance with; guidelines, key demographic information and key outcomes relative to the use of psychotropic medications and the numbers of various medications based on the type and age of the child. The medication request is reviewed by the CMCU who considers the clinical situation as provided by the prescriber, monitoring requirements, maximum dosing guidelines and combination of medications. The dosing guidelines and monitoring requirements are based on the recommendations made by the Psychotropic Medication Advisory Committee (PMAC). This committee consists of public and private pharmacists, nurse practitioners, child psychiatrists, pediatricians, registered nurses, and parent advocates, and is chaired by a DCF child psychiatrist. PMAC is also charged with reviewing any reported adverse drug reaction and regularly reviews various medications for inclusion or exclusion on the agency formulary.

Behavioral Health Partnership:

Beacon Health Options (formerly Value Options) As Connecticut's Behavioral Health ASO, Beacon manages directly contracted, publicly-funded behavioral health care programs including: Emergency Departments, Inpatient, PRTF and IICAPS. Each year together with all three state agencies (DCF, DSS and DMHAS), performance targets are established relative to #'s served, length of service, appropriate discharge, level of care authorization, connect to care, etc. Reports are readily available on Beacon's website and utilization data is accessible to Central Office and the Regions through a SharePoint site. Though there are a large number of performance targets and reports available, the Department at times, has also requested ad hoc reports. In addition, DCF has entered into a specific contract with Beacon managing a newer program known as ACCESS MH. This partnership is managed through a PDOC, overseeing the contract and reviewing quarterly data from Beacon's Encounter System and detailed reports that are discussed with each of the three hubs on a quarterly basis.