Continuous Quality Improvement
2015 IA Case Record Review
Executive Summary

In 2015, the Wisconsin Department of Children and Families (DCF) reviewed a representative sample of 271 Initial Assessments (IAs) conducted throughout the state to determine the overall quality of IA practice statewide. Initial Assessment is a central function of child protective services in which child welfare agencies conduct a comprehensive evaluation of the child and family in response to a screened-in report of alleged maltreatment. Information related to individual and family conditions, functioning, and dynamics is gathered and analyzed, and the Initial Assessment concludes with a maltreatment determination about the allegations of abuse and/or neglect and determines whether the family is in need of ongoing services to keep the child safe.

Goals of Review

The 2015 Initial Assessment case record review focused on three main goals and a fourth long-term goal:

Goal 1: Establish a statewide baseline for CPS Initial Assessment practice as measured by adherence to Access and Initial Assessment Standards and Safety Intervention Standards

Goal 2: Identify practice areas needing improvement that warrant further analysis and may be candidates for improvement projects.

Goal 3: Test the new case record review process.

Goal 4: In the long term, use the review findings to identify practices that result in positive outcomes for children and families and update Standards where necessary.

The report focuses primarily on the first and second goals and provides information about the third goal in the report appendices (Appendix A). The fourth goal is a long-term goal for all continuous quality improvement initiatives and will be evaluated in future reports.

The report provides case record review results about adherence to Standards in CPS case practice and decision-making during Initial Assessment. Moving forward, the CQI case record review results can be used in combination with other information sources to identify challenging areas of practice and inform improvement projects. Further case record reviews and analyses, as well as subsequent improvement projects based on review results, will provide opportunities to continue enhancing DCF services and promoting positive outcomes for children and families in Wisconsin.

INTERVIEW CONTACTS

When all victims were met face-to-face within the response time assigned at Access, all three IA conclusions (safety determination, maltreatment determination, and case disposition) were more likely to be consistent with Standards.

Timely face-to-face contact with *all* alleged victims occurred in 66% of the IAs reviewed and with at least *some* of the alleged victims in an additional 12% of cases; in 22% of cases reviewed *none* of the alleged victims were met within the assigned timeframe. When all face-to-face contacts were made timely, the safety determination was consistent with Standards 83% of the time compared to 65% when contact was not made timely.

Making contact with all collaterals necessary for understanding safety in the specific case under review also significantly increased the likelihood of having a safety determination consistent with Standards.

In the majority of Initial Assessments (72%) reviewed, all necessary collateral contacts were made; 28% of IAs were missing at least one necessary collateral contact. A contact was considered necessary when he or she was likely to have had information that would have been critical in understanding safety in the specific case under review. When all necessary collateral contacts were made, the safety determination was consistent with Standards 90% of the time compared to 43% of the time when the IA was missing one or more necessary collateral contacts.

> *"In the majority of Initial Assessments reviewed, all necessary collateral contacts were made."*

Adherence to interview protocols related to the Wisconsin Indian Child Welfare Act varied.

Screening for American Indian heritage for each child in the household was documented in two-thirds of the cases reviewed. On the other hand, of the 21 cases where American Indian heritage was referenced, only 3 (14%) included documentation that consultation with the tribal agency occurred.

INFORMATION GATHERING

The average Initial Assessment comprehensively documented 34% of the applicable information items measured in the review instrument.

The review instrument was designed using a broad, all-inclusive approach to measure items of information outlined in Standards and appendices that define the required areas of assessment. In total, 49 information items related to Primary Initial Assessments were generated (though not all 49 items were applicable in all cases). While the average IA reviewed had approximately one-third of applicable items comprehensively documented, the range was between 0% and 93%. No IA reviewed had all applicable information items comprehensively documented, which is likely a reflection of the methods used to create this section of the review instrument. This approach was a necessary starting point for measuring a baseline of information gathering. However, DCF is reflecting on ways to adjust the review instrument to better gauge documentation of specific items, as well as to assess the totality of information gathering and the analytic process used to assess the information gathered to make safety and substantiation decisions.

INFORMATION GATHERING

When more than half of the information items were comprehensively documented during the Initial Assessment, the resulting safety determination and case disposition were consistent with Standards 98% of the time.

When examining aggregate levels of information gathering, the more information items that were comprehensively documented, the more likely it was that the IA had conclusions consistent with Standards. However, it is still relatively unknown how specific, individual items of information (such as domestic violence, or discipline methods) relate to decisions that are consistent with Standards.

The frequency with which specific information items were comprehensively documented varied greatly, between 6% and 74% of IAs reviewed.

The information items most frequently documented pertained to the areas of Maltreatment and Surrounding Circumstances. The items least frequently documented were in the areas of Parenting Practices, Family Functioning, and Discipline, which relate directly to parental protective capacities.

Initial Assessments that were approved timely were more likely to have more information comprehensively documented.

IAs that were completed within 60 days had 36% of the applicable information items comprehensively documented, on average, compared to 30% for those that took longer than 60 days to complete. Additionally, there was more information comprehensively documented when children were identified as unsafe and when allegations were substantiated. The level of documentation also varied depending on the type of maltreatment allegation.

PRESENT AND IMPENDING DANGER ASSESSMENT

When there was sufficient documentation, assessments of present and impending danger were generally consistent with Standards.

The majority of IAs reviewed identified or ruled out present and/or impending danger in a manner consistent with Standards. Less than 10% of IAs reviewed were inconsistent with Standards when assessing for present and/or impending danger.

There were several cases that lacked sufficient documentation needed for reviewers to determine if the assessment of present and/or impending danger was or was not consistent with Standards.

At least 10% of IAs were missing key information necessary to determine if the identification (or lack thereof) of Present Danger Threats was consistent with Standards. For the assessment of impending danger the proportion was even higher—nearly 23% of all IAs reviewed were missing key information. In the majority of these cases, the local child welfare agency had not identified any Impending Danger Threats.

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PROTECTIVE PLANS AND SAFETY PLANS

The overall quality and adequacy of protective and safety planning is relatively unknown.

Part of the review focused on evaluating protective plans and safety plans, but few were captured in the random sample. Forty-five IAs contained a safety plan, only 9 of which were in-home. Fifty-five IAs had a protective plan or action documented in eWiSACWIS, 15 of which were Protective Plan documents scanned into the electronic case record.

Needed protective plans are not well documented in eWiSACWIS.

There were 55 IAs that had a documented protective plan/action; 15 of these used a Protective Plan document. However, an additional 7 IAs referenced a Protective Plan document (or needed one based on local agency identification of Present Danger Threats) but did not have one documented in eWiSACWIS. This amounts to roughly one-third of needed Protective Plan documents missing from the electronic case record. It is worth noting that at the time of the review Standards did not explicitly require Protective Plan documents to be scanned into eWiSACWIS, though it is best practice.

DECISION MAKING

There was a notable proportion of cases (between 16% and 21%) that lacked the supporting documentation necessary to determine the accuracy of IA conclusions.

The lack of supporting documentation could relate to the fact the Initial Assessment template is set up in a way to encourage the collection of information related to specific areas of assessment with no explicit way to document the analysis of the information in reaching these conclusions.

It is also possible that it is easier for reviewers to confirm a finding of unsafe and/or substantiated, and in the majority of cases, children are found to be safe and maltreatment allegations are unsubstantiated. While these are possible explanations for this finding, it also indicates that the system as whole may be missing opportunities to engage with families. A screened-in report of alleged maltreatment gives child welfare agencies an authorized opportunity to interview a family. If key information is not gathered and documented during the Initial Assessment, then the chance to interact with that family is lost until a community member makes another referral to CPS. If sufficient information is gathered and analyzed to arrive at the right conclusions, however, it may help in ensuring positive outcomes for children and their families.

When there was sufficient information documented to assess decision-making, the Initial Assessments reviewed frequently (between 77% and 80%) included decisions that were consistent with Standards.

Maltreatment determinations were found to be consistent with Standards in 80% of cases reviewed. Safety determinations were found to be consistent with Standards 77% of the time. IA case disposition was found to be consistent with Standards 80% of the time. There were very few cases (between 2% and 3%) where decisions made were inconsistent with Standards (e.g., a case was closed at the conclusion of the IA when it should have been opened for Ongoing Services).

> *"There were very few cases where decisions were inconsistent with Standards."*

PROCEDURAL LESSONS LEARNED

In addition to the case record review results, there were several important findings relating to the review process itself, which was also being tested as part of the first IA review under the new CQI system.

Some results may be biased due to the design of the review instrument or procedures followed to review cases.

For example, though reviewers were randomly assigned Initial Assessments to review, if a decision was found to be inconsistent with Standards, the case was sent to a secondary review panel for confirmation, which may have artificially inflated results. With respect to information gathering, results may be biased to a lower percentage because the review only gave credit for comprehensive documentation if the information item was in the corresponding section of the IA template.

The review instrument itself may also have biased information gathering results to a lower percentage, as it was designed to measure documentation of specific information items outlined in Standards and appendices using a broad, all-inclusive approach. This approach was a starting point, but led to the realization that it requires a great deal from workers and expectations are often unclear. Therefore, the methods used to design this section of the review instrument may have unintentionally produced lower results, which are not necessarily a reflection of what is happening at the local level.

Enhancements to the Initial Assessment review instrument were identified.

The review process identified questions that were not considered when the review instrument was being developed and tested. Updating the instrument will provide additional opportunities for analysis and a deeper understanding of case practice.

Additionally, reviewers completed the review instrument on paper; converting the review instrument into an electronic database system will cut down on additional time needed for quality management activities in future reviews.

More time was needed to train new reviewers.

The time invested supporting new reviewers was greater than their case review output, as the IA reviews were not their primary job responsibility, and there was a tight timeframe in which reviews were conducted. In the future, new reviewers will be offered more time to complete prerequisite training with additional coaching opportunities.

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RECOMMENDATIONS

The baseline results and findings related to IA case practice brought forth the following recommendations:

Gather data from Initial Assessment workers and conduct additional analyses related to information gathering and interview contacts.

More information is needed to better understand the variation in information documented. IA workers and supervisors could provide valuable insight into why certain items of information are documented more frequently than others, as well as the role of specific information items in decision-making. IA workers could also provide insight into Standards, practice, and workload when it comes to meeting timeline requirements for contact with alleged victims and contacting necessary collaterals.

Conduct an additional or separate review of protective plans and safety plans.

A specialized review could be used to better assess the quality and adequacy of protective and safety planning across the state. Because there is a variety of protective plans and safety plans that can be used throughout the IA process, and each plan has different requirements and protocols, a different approach is needed to extrapolate trends related to this area of IA case practice.

Collect information to better understand how the analytic process of assessing for present and impending danger is happening in practice.

Wisconsin's safety model encourages the use of a rigorous analytic process in assessing for threats to child safety. More information is needed to understand how workers are utilizing and documenting this process. Focus groups and interviews with workers and supervisors, as well as improvements to the IA review instrument, could help provide insight into how workers are analyzing information gathered to arrive at child safety decisions. Depending on the information gleaned, enhanced safety-related training to support improvements in the assessment and decision-making analytic process could be provided to workers and supervisors.

Further examine the relationship between information gathering and positive outcomes for children and families.

The ultimate goal of the CQI case record reviews is to use the results to identify areas of practice that are correlated with beneficial outcomes. Additional studies could examine the relationship between thorough information gathering and documentation and the long-term outcomes of child safety, permanency, and well-being.