Continuous Quality Improvement (CQI)

2015-2016 Ongoing Services Case Record Review

Report

Wisconsin Department of Children and Families
Division of Management Services
Bureau of Performance Management
Quality Review and Performance Analysis Section

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Introduction and Goals of Review

A central function of child welfare agencies is the provision of Ongoing Services. When a child is found to be unsafe and there are certain family conditions that warrant child welfare or child protective services (CPS) intervention, a case is opened for Ongoing Services. Such cases can be opened on a voluntary basis or by a court order. The primary role of the child welfare agency in Ongoing Services is to engage families in a positive relationship to achieve a safe, stable home and permanence for children.[1] These three areas of focus—safety, permanency, and well-being—are the pillars of child welfare:

1) Safety: Safety intervention in CPS cases is a continual process that concludes with case closure. It focuses on assessing for and controlling impending danger while collaborating with parents to establish protective capacities that minimize risk factors, keep children safe from harm, and provide a safe, nurturing environment.

2) Permanency: When a child is placed in out-of-home care, the goal of the child welfare agency is to achieve legal permanence through reunification, adoption, or guardianship. This means that the child has a relationship with a parenting adult that is recognized by the law (e.g., adoptive parent, birth parent, or legal guardian). Planning for permanency includes establishing and maintaining lifelong connections with siblings, extended family, and caregivers so that the child can have healthy, long-term relationships in a stable, loving environment.

3) Well-Being: A child's well-being is dependent upon the caretaker's ability to meet his or her physical health, mental/behavioral health, educational, and cultural needs. Agencies make efforts to assess child and adult needs in these areas and address any identified needs as part of case planning activities. Children and families are meaningfully engaged in all aspects of service coordination to build and maintain lasting relationships that are trusting and supportive.

As part of the redesigned Child Welfare Continuous Quality Improvement (CQI) System, the Wisconsin Department of Children and Families (DCF) set out to conduct a case record review[2] to assess the overall quality of practice in Ongoing Services across the State of Wisconsin.[3] The review commenced in late 2015 and was completed in early 2016.

This is the last of three reports on 2015 statewide case record reviews and the first on the review of Ongoing Services under the new Child Welfare CQI System. The purpose of this report is to summarize the Ongoing Services case record review findings and highlight key results and recommendations for future reviews.

[1] As outlined in the Wisconsin Department of Children and Families Ongoing Services Standards; see more at: https://dcf.wisconsin.gov/files/cwportal/policy/pdf/ongoing-services-standards.pdf.

[2] Within the new Child Welfare CQI System, the DCF Bureau of Performance Management (BPM) is tasked with developing and implementing case record review instruments and review processes, as well as analyzing the resulting data and writing reports. BPM is part of the Division of Management Services, which works across the Department's program divisions. BPM works closely with the Division of Safety and Permanence, which has oversight authority for the state's child welfare system.

[3] Wisconsin has a state-supervised, county-administered child welfare system. Local human services agencies (in 71 of the 72 counties) are responsible for child welfare service delivery with oversight from the Department of Children and Families. In Milwaukee County, DCF directly administers child welfare services through the Division of Milwaukee Child Protective Services.

Background

Wisconsin's Redesigned Child Welfare CQI System

In 2014, the Wisconsin Department of Children and Families began revising its child welfare-related CQI processes to make them more informative and integrated into its responsibilities for oversight of the state's child welfare system. DCF, in partnership with local child welfare agencies, the courts, and other partners have established the following mission for the state's Child Welfare CQI System:

> *Wisconsin is committed to a Continuous Quality Improvement (CQI) system that supports the assessment and improvement of child welfare practice, processes, and outcomes at the state and local level. The Wisconsin Department of Children and Families fulfills this mission by providing resources, tools, and processes to build and sustain CQI at the state and local level.*

The focus of the new Child Welfare CQI System is to create a deeper understanding of all child welfare practice areas. To this end, DCF developed new child welfare case record review instruments and processes for each stage of interaction with Wisconsin's Child Protective Services system: Access, Initial Assessment, and Ongoing Services. The revised case record review process provides a robust understanding of the CPS aspect of child welfare practice in the state by examining a representative sample of cases. However, as part of the new Child Welfare CQI System, case record reviews play a different role in that the results are considered one of many data sources, rather than a singular source of information, conclusions, or analysis upon which to act.[4]

In its redesign of the Child Welfare CQI System, Wisconsin incorporated relevant federal requirements. Federal regulations require all states to have a quality assurance system in place to regularly assess the services provided under their Child and Family Services Plan. In 2012, the federal government directed states to adopt a CQI approach to quality assurance.[5]

CQI and the Federal Child and Family Services Review

Because a CQI system focused on the performance of the state's child welfare system is a federal requirement, Wisconsin's Child Welfare CQI System will be assessed during the next federal Child and Family Service Review (CFSR). The CFSR, which occurs every five to seven years, is a review of state child welfare systems that focuses on: (1) ensuring conformity with federal child welfare requirements; (2) determining what is happening to children and families engaged in state services; and (3) assisting states in achieving positive outcomes for children and families. Wisconsin's Round 3 CFSR is scheduled for federal fiscal year 2018.

One component of the CFSR is the collection of information through case reviews.[6] To align with federal requirements, Wisconsin adopted the CFSR Onsite Review Instrument (OSRI)[7] to review Ongoing Services cases when the state transitioned from the Quality Services Review (QSR) protocol in 2015.

[4] In the past, the results of individual case reviews were the primary focus and identified areas in need of improvement. Based on the results of the case review, the county would develop an action plan for training and staff development.

[5] For more information, please see: https://dcf.wisconsin.gov/cqi.

[6] In addition to the seven outcome areas related to safety, permanency, and well-being—which are assessed through case reviews and interviews—the CFSR also assesses seven systemic factors. See Appendix 1 for a full list.

[7] For a copy of the federal review instrument, see https://training.cfsrportal.org/resources/.

This report provides the results and lessons learned from the first round of reviews using this instrument. It assesses seven outcomes (made up of 18 specific items) focusing on safety, permanency, and child and family well-being:

- Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.
    - Item 1: Timeliness of Initiating Investigations of Reports of Child Maltreatment
- Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.
    - Item 2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care
    - Item 3: Risk and Safety Assessment and Management
- Permanency Outcome 1: Children have permanency and stability in their living situations.
    - Item 4: Stability of Foster Care Placement
    - Item 5: Permanency Goal for Child
    - Item 6: Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement
- Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.
    - Item 7: Placement With Siblings
    - Item 8: Visiting With Parents and Siblings in Foster Care
    - Item 9: Preserving Connections
    - Item 10: Relative Placement
    - Item 11: Relationship of Child in Care With Parents
- Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.
    - Item 12: Needs and Services of Child, Parents, and Foster Parents
    - Item 13: Child and Family Involvement in Case Planning
    - Item 14: Caseworker Visits With Child
    - Item 15: Caseworker Visits With Parents
- Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.
    - Item 16: Educational Needs of the Child
- Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.
    - Item 17: Physical Health of the Child
    - Item 18: Mental/Behavioral Health of the Child

For a more detailed description of the items, see Appendix 1, which contains a reference list provided by the federal government of all items for each outcome and systemic factor.

Throughout this report, the federal language used in the instrument is updated to reflect terminology in Wisconsin practice and standards. (For example, "foster care" is out-of-home care; "investigations of reports of child maltreatment" are Initial Assessments.)

Goals for the 2015-2016 Review of Ongoing Services

The 2015 Ongoing Services case record review had three primary goals and a fourth long-term goal.

Goal 1: Test a new case record review process for Ongoing Services. The first goal was to test the new case record review process and become familiar with the federal Onsite Review Instrument (OSRI). DCF used the 2015 review to establish protocols and ensure the review provides information needed to understand the strengths and challenges of Ongoing Services throughout Wisconsin.

Goal 2: Obtain a statewide baseline of Ongoing practice. The second goal was to establish a statewide baseline for Ongoing Services as measured by the CFSR OSRI. A representative sample informs Wisconsin's performance as it relates to the outcomes assessed in the federal case review.

Goal 3: Prepare for the Round 3 CFSR. Wisconsin is scheduled for Round 3 CFSR in federal fiscal year 2018.

Goal 4: Improve outcomes for children and families. Safety, permanency, and well-being are the focus of Ongoing Services. The long-term goal of all reviews conducted as part of Wisconsin's Child Welfare CQI System is to understand how practice impacts these outcomes for children and families who have interacted with CPS in the state.

Methodology

Review Process

The Ongoing Services case record review was managed by expert reviewers from the DCF Quality Review unit, who oversaw training, coaching, review procedures, and quality management. Trained case reviewers were randomly assigned cases and reviewed only information recorded in Wisconsin's Statewide Automated Child Welfare Information System (eWiSACWIS). Both in-home and out-of-home care (OHC) cases were reviewed.

The OSRI assesses certain items differently depending on the case type. For example, only OHC cases are assessed for permanency outcomes, as children receiving in-home services already live with their parent/caregiver(s). Additionally, the review instrument only assesses those items for the target child in OHC and not for other children in the family. On the other hand, all children residing in the home are assessed for items specific to safety for both in-home and OHC cases.

Sample Selection

In order to examine Ongoing Services practice throughout Wisconsin, DCF sought to compile a statewide, representative sample of cases in a manner consistent with CFSR requirements (which included a prescribed ratio of 40 out-of-home care cases to 25 in-home cases, or 1.6). The sample also had to be large enough to detect statistically significant changes in results from year to year—for a total of 271 cases, based on sample size estimates from previous CQI reviews. The CFSR case inclusion criteria below were followed:

- OHC cases in which the target child was in an open placement for at least one day during the defined period under review (PUR)
- In-home cases that were open for at least 45 days during the PUR
- In-home cases that opened after 1/1/2012

Data from the eWiSACWIS *SM10A112 Placement Activity and Detail Report* was used to randomly select target children for review of OHC cases. The sample was proportionally divided between Milwaukee and Balance of State cases, and included an oversample of cases so that any case meeting elimination criteria could be swapped out for a different case. A total of 450 out-of-home care cases (108 from Milwaukee and 342 from the Balance of State) were randomly selected for the sample and oversample.

Data from the eWiSACWIS *SM04A103 Case Assignment Report* was used to randomly select families for review of in-home cases. Because it was anticipated that there would be a larger need for swapping out cases (given the difficulty in identifying open in-home cases due to data limitations), the sample of in-home cases was compiled by randomly ordering all cases in the population and vetting them one by one to ensure that they met inclusion criteria and that no case elimination criteria applied.

Case elimination criteria defined by the CFSR are as follows:

- Cases opened solely for subsidized adoption or guardianship payment
- Cases in which the target child reached the age of majority as defined by state law before PUR
- Cases in which the child is or was in the placement and care responsibility of another state, and the state under review is providing supervision through an Interstate Compact for Placement of Children (ICPC) agreement
- Cases appearing multiple times in the sample, such as a case that involves siblings in foster care

- OHC cases in which the child's adoption or guardianship was finalized before the PUR and the child is no longer in foster care
- Cases in which the child was placed for the entire PUR in a locked juvenile facility or other placement that does not meet the federal definition of foster care as defined in 45 CFR § 1355.20.

For the purposes of the CQI review, DCF defined additional elimination criteria:

- Juvenile Justice-only cases
- Cases served by Tribal Court only
- Cases opened for reasons other than abuse or neglect
- Cases served by another state (child/caregiver residing outside of Wisconsin during entire PUR)
- Open cases with no case documentation during PUR.

Data Collection

The review was conducted using the federal CFSR Online Monitoring System (OMS), which houses the OSRI and stores data from each case review completed. As noted, reviewers used the OSRI to record data on cases selected from the random sample during a set period under review (PUR). The PUR for the 2015-2016 Ongoing Services case record review examined case practice from July 1, 2014 (PUR start date) to either the date that the reviewer began the case review *or* December 31, 2015 (PUR end date), whichever came first. The maximum PUR was 18 months.

Limitations

Despite in-depth training and a robust quality management plan, the results of the case record review have limitations stemming from the review process design. It is important to keep these limitations in mind when interpreting results. (A complete description of these limitations and further details about the review process are provided in Appendix 3.)

- Reviewers could rely solely on information in eWiSACWIS, so the results do not reflect what may be found in paper files or gathered from interviews.
- While a representative sample of cases (271) were reviewed, not every question in the OSRI was applicable for every case, resulting in limited in-depth analysis.
- The period under review varied for the cases reviewed which could affect results. (For example, a case with a longer PUR may be more likely to show a child with a higher number of OHC placements.)
- During the course of the review period the federal CFSR OSRI was updated, which may have impacted results.

Results and Discussion

Review Sample

A total of 271 Ongoing Services cases from Milwaukee and the Balance of State (BOS) were assigned to reviewers. For out-of-home care, 172 unique cases were assigned. Of these, 8 were assigned to multiple reviewers—3 as a group training opportunity and 5 as a "double blind" case, where two different reviewers unknowingly completed the same case to test inter-rater reliability. During the course of the review, 54 cases (49 BOS and 5 Milwaukee cases) had to be swapped out of the sample and replaced because they did not fit the criteria for review upon further examination.[8] For in-home cases, 100 unique cases were assigned to reviewers. Before reaching the target assignment of 100 cases from the random-ordered list, 178 cases (131 BOS and 47 Milwaukee cases) had to be eliminated from the sample.[9]

In the end, a total of 285 reviews were completed in the CFSR OMS. These reviews were conducted on a total of 274 unique cases. Though the final sample of cases reviewed achieved the size and level of representativeness intended, there were several discrepancies between the cases assigned and those reviewed. For example, of the 274 cases, there were 175 OHC cases, whereas 172 were assigned, and there were 99 in-home cases, whereas 100 were assigned. Additionally, 10 OHC cases reviewed were not originally assigned and 3 that were assigned were not reviewed (which was likely due to a typo in case number or error in tracking). Issues identified in the case assignment process led to a Lean project, which generated methods to improve case assignment in future reviews.

Another issue that was not anticipated was the need to account for multiple children in the same OHC case. A total of 3 cases were captured in the random sample twice for two different target children. Two of these cases were, by chance, assigned to the same reviewer, leaving no unique identifier or ability to match to administrative data because cases were tracked in the OMS by reviewer name and case ID (and did not include child ID). Therefore, they were removed for analysis, as was the third case for consistency. An additional case was removed because the same child was included on two different cases. Duplicated ("double blind") cases were also deleted for data analysis. This left a total of 172 unique OHC cases and 271 cases overall. (Additional details regarding the methods and tools used to collect data and conduct analyses of this data are presented in Appendix 3.)

Table 1 shows the breakdown of the random sample compared to the population of cases from which it was drawn.

[8] Reasons for swapping out OHC cases included: wrong case type (Juvenile Justice-only case, served by Tribal Court, in-home case or less than 24 hours in care, case opened for reasons other than abuse or neglect); case was closed prior to the PUR; child reached the age of majority prior to the PUR; case was served by another state.

[9] Reasons for swapping out in-home cases included: wrong case type (Juvenile Justice-only case, child was in OHC placement for at least 1 day); case was closed prior to the PUR; case was open for fewer than 45 days; case served by another state; open case with no documentation in case file.

Table 1: Cases in the Random Sample

	Review Sample		Population‡	
	N	%	N	%
Out-of-Home Care				
Balance of State	119	69.2%	9,432	65.6%
Milwaukee	53	30.8%	4,921	34.4%
In-Home Services				
Balance of State	67	67.7%	7,662	80.2%
Milwaukee	32	32.3%	1,891	19.8%

‡All cases meeting inclusion criteria during the period under review.

While the random sample was generally representative, in-home cases from Milwaukee County are slightly overrepresented based on proportion. Once inclusion and elimination criteria were applied to the case universe, the proportion of cases pertaining to Milwaukee County was smaller for in-home cases than for all Ongoing Services cases, a split that was not anticipated when compiling the random sample and assigning cases.

All OHC cases focused on a single target child. An additional 36 in-home services cases had only a single child on the case, while the remaining in-home cases had up to 9 children in the home, for a total of 399 children in the sample.

Table 2 shows basic characteristics of the children whose cases were captured in the random sample, including race and age at the time of the review.

Table 2: Children in the Case Review Sample

Demographic Characteristics		Children‡ N	Children‡ %
Age at Time of Review	0 to 3	90	23%
	4 to 7	99	25%
	8 to 12	104	26%
	13 and older	106	27%
Race/Ethnicity	Hispanic (any race)	54	14%
	Non-Hispanic		
	One Race		
	American Indian*	12	3%
	Black	121	30%
	White	168	42%
	Other	3	1%
	Two or More Races	18	5%
	Unknown	23	6%

‡ Each OHC case focused on a single, "target" child, and therefore contained one child each. In-home cases included the entire family—between 1 and 9 children in same household.

* Denotes race; not necessarily indicative of tribal membership or eligibility.

Summary of 2015 Results

Through case reviews, the CFSR measures seven outcomes[10] related to the safety of children (in or out of their homes), achieving permanent living situations for children in out-of-home care, and providing services to meet families' needs and ensure the well-being of children. Each outcome is made up of one or more items, for a total of 18 items. The seven outcomes are scored as *Substantially Achieved*, *Partially Achieved,* or *Not Achieved,* based on the ratings of items that make up each outcome. Not every case is rated for every item, as applicability varies from case to case.[11]

Table 3 shows the outcome scores derived from the item ratings. In order for a state to be in "substantial conformity"[12] with an outcome, 95% of applicable cases must be rated as *Substantially Achieved* for that outcome. Based on the above criteria and the results obtained during the CQI review, Wisconsin was not in substantial conformity with any of the seven outcomes.

Table 3: CFSR Outcomes for Cases Reviewed

	Items	Substantially Achieved	Partially Achieved	Not Achieved	No. Cases Assessed
Safety Outcomes:					
1 Children Are, First and Foremost, Protected From Abuse and Neglect	1	76%	--	24%	114
2 Children Are Safely Maintained in Their Homes Whenever Possible	2-3	64%	18%	17%	271
Permanency Outcomes:					
1 Children Have Permanency and Stability in Their Living Situations	4-6	34%	60%	6%	172
2 The Continuity of Family Relationships Is Preserved for Children	7-11	56%	38%	5%	170
Well-Being Outcomes:					
1 Families Have Enhanced Capacity to Provide for Their Children's Needs	12-15	46%	39%	14%	271
2 Children Receive Appropriate Services to Meet Their Educational Needs	16	87%	2%	11%	180
3 Children Receive Adequate Services to Meet Their Physical and Mental Health Needs	17-18	59%	16%	25%	252

[10] The CFSR assesses seven outcome areas related to safety, permanency, and well-being through case reviews, as well as seven systemic factors. See Appendix 1 for a full list of items.

[11] All in-home cases are excluded from assessment of permanency outcomes. Additionally, there are other case-specific circumstances rendering a case not applicable for assessment of a certain item altogether, or excluded from a specific question pertaining to an item.

[12] "After the completion of the onsite review phase of the Child and Family Services Review, whether for a State Conducted Case Review or a Traditional Review, the Children's Bureau makes a determination regarding substantial conformity for each of the seven outcomes and seven systemic factors under review based on the requirements set forth at 45 CFR § 1355.34. The Children's Bureau submits these findings, along with information on the state child welfare agency's strengths and areas needing improvement in serving children and families, to the state in a Final Report prepared by the Children's Bureau after all data have been obtained. A Program Improvement Plan is required only for outcomes or systemic factors determined not to be in substantial conformity" (*Child and Family Services Reviews Procedures Manual*, November 2015, p. 47).

Each item is rated as a *Strength* or *Area Needing Improvement*, depending on the answers to the review instrument questions. Table 4 shows Wisconsin's item ratings based on the 2015-2016 CQI review. To receive an overall *Strength* rating for an item, 90% of cases reviewed must be rated as a *Strength*. The exceptions to this benchmark are Item 1 and Item 16, where the requirement is 95%. Based on these criteria, each of the 18 items was an *Area Needing Improvement*.

Table 4: Item Ratings

			Strength	Area Needing Improvement	No. Cases Assessed
Safety Outcome 1	**Item 1:**	**Timeliness of Initiating Investigations of Reports of Child Maltreatment**	76%	24%	114
Safety Outcome 2	**Item 2:**	**Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care**	88%	12%	114
	Item 3:	**Risk and Safety Assessment and Management**	64%	36%	271
Permanency Outcome 1	**Item 4:**	**Stability of Foster Care Placement**	82%	18%	172
	Item 5:	**Permanency Goal for Child**	54%	46%	170
	Item 6:	**Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement**	66%	34%	172
Permanency Outcome 2	**Item 7:**	**Placement With Siblings**	86%	14%	119
	Item 8:	**Visiting With Parents and Siblings in Foster Care**	57%	43%	157
	Item 9:	**Preserving Connections**	75%	25%	167
	Item 10:	**Relative Placement**	62%	38%	165
	Item 11:	**Relationship of Child in Care With Parents**	67%	33%	147
Well-Being Outcome 1	**Item 12:**	**Needs and Services of Child, Parents, and Foster Parents**	52%	48%	271
	Item 13:	**Child and Family Involvement in Case Planning**	67%	33%	264
	Item 14:	**Caseworker Visits With Child**	69%	31%	271
	Item 15:	**Caseworker Visits With Parents**	48%	52%	250
Well-Being Outcome 2	**Item 16:**	**Educational Needs of the Child**	88%	12%	180
Well-Being Outcome 3	**Item 17:**	**Physical Health of the Child**	61%	39%	205
	Item 18:	**Mental/Behavioral Health of the Child**	77%	24%	149

The sections below describe the results more in-depth by section (Safety, Permanency, and Well-Being).

Safety Outcomes

Safety Outcome 1: Children Are, First and Foremost, Protected From Abuse and Neglect

Safety Outcome 1 is composed of one item. The purpose of assessment is to "determine whether responses to all accepted child maltreatment reports received during the period under review were initiated, and face-to-face contact with the child(ren) made, within the time frames established by agency policies or state statutes."[13] Safety Outcome 1 was *Substantially Achieved* in 76% of cases and *Not Achieved* in 24% of cases (as noted in Table 3).

Safety Outcome 1, Item 1

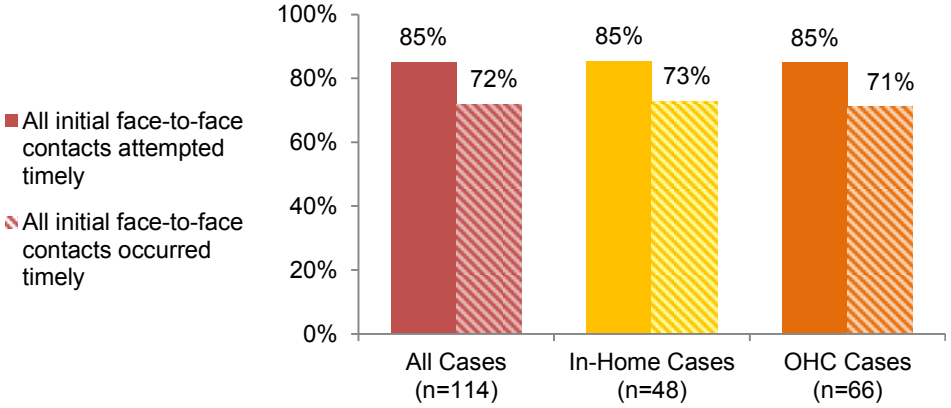
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 1:	**Timeliness of Initiating Investigations of Reports of Child Maltreatment**	76%	24%	114	*95%*

Item 1 measures the timeliness of agencies' responses to reports of alleged abuse and neglect. Cases are assessed for this item if there is at least one screened-in report of alleged maltreatment during the period under review. A total of 114 cases were assessed.

In order to receive a *Strength* for this item, there had to be a successful attempt at face-to-face contact with all alleged victims within the assigned response time for all Initial Assessments. (If the case is rated as a *Strength* for this item, the outcome is *Substantially Achieved*, as this outcome has a one-to-one relationship with the item that makes up its score). As shown in Table 4, 76% of cases received a *Strength* rating for Item 1. It is worth noting that if there were reasons for delay due to circumstances outside the agency's control then the case still receives a *Strength* rating.[14]

Figure 1 shows initial face-to-face contacts for Initial Assessments that occurred during the period under review. Face-to-face contact was attempted timely[15] in a total of 85% (97) of applicable cases, and face-to-face contact was completed timely in 72% (82) of applicable cases.

Figure 1. Initial Face-to-Face Contacts During the Period Under Review



[13] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.7)

[14] This occurred in 5 cases.

[15] Reviewers read through the case file and all case notes to assess the item based on what actually occurred, which could account for any discrepancies with administrative data.

Safety Outcome 2: Children Are Safely Maintained in Their Homes Whenever Possible and Appropriate

Safety Outcome 2 is composed of two items intended to determine whether the agency made concerted efforts to (1) provide services to prevent children's entry or re-entry into out-of-home care and (2) assess safety concerns relating to the children in their own home or while in out-of-home care. Safety Outcome 2 was *Substantially Achieved* in 64% of cases, *Partially Achieved* in 18% of cases, and *Not Achieved* in 17% of cases (as noted in Table 3).

Safety Outcome 2, Item 2

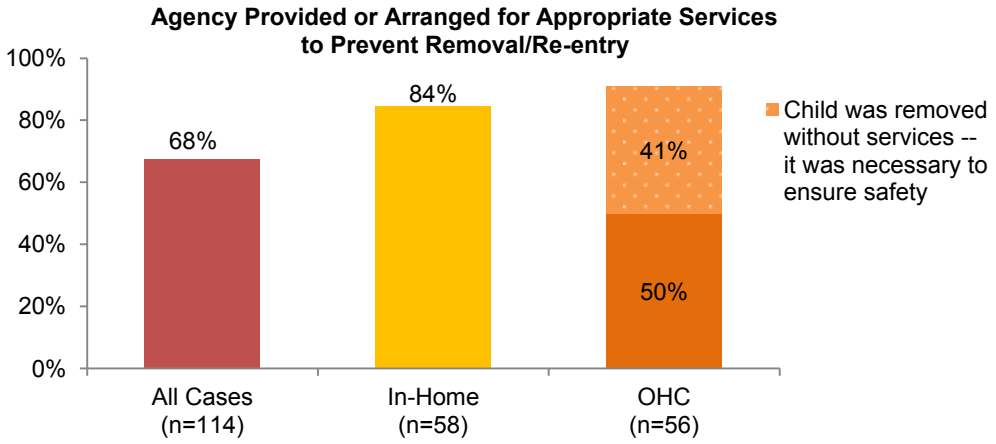
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 2:	**Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry**	88%	12%	114	*90%*

Item 2 measures agencies' efforts to provide safety-related services to protect children and prevent their entry or re-entry into out-of-home care. In Wisconsin, this comes in a variety of forms, including protective planning to assess for impending danger, court-ordered in-home services, voluntary services, and referrals to community response programs. Any case where there was at least one child in the family residing at home during any portion of the period under review (e.g., reunified during PUR, temporary physical custody after the PUR start date, etc.) is assessed for Item 2. In total, 114 cases were assessed.

If the agency made efforts to provide or arrange for appropriate services, the case receives a *Strength* rating. However, if services were not provided because the child was removed due to immediate safety threats, the case still receives a *Strength.* There were 114 cases assessed for this item, 88% (100) of which were rated as a *Strength*.

Figure 2 shows agency efforts to provide and/or arrange for services necessary to prevent entry into OHC (or re-entry after reunification). In a total of 68% (77) of cases, the agency demonstrated concerted efforts to obtain appropriate services for the family. This was true for 84% (49) of in-home cases and 50% (28) of OHC cases. It is worth noting, however, that in 41% (23) of OHC cases, the child did not receive such services because he or she had to be removed from the home to ensure safety before they could be arranged for or provided.

Figure 2. Agency Efforts to Provide Services to Prevent Removal or Re-Entry



Safety Outcome 2, Item 3

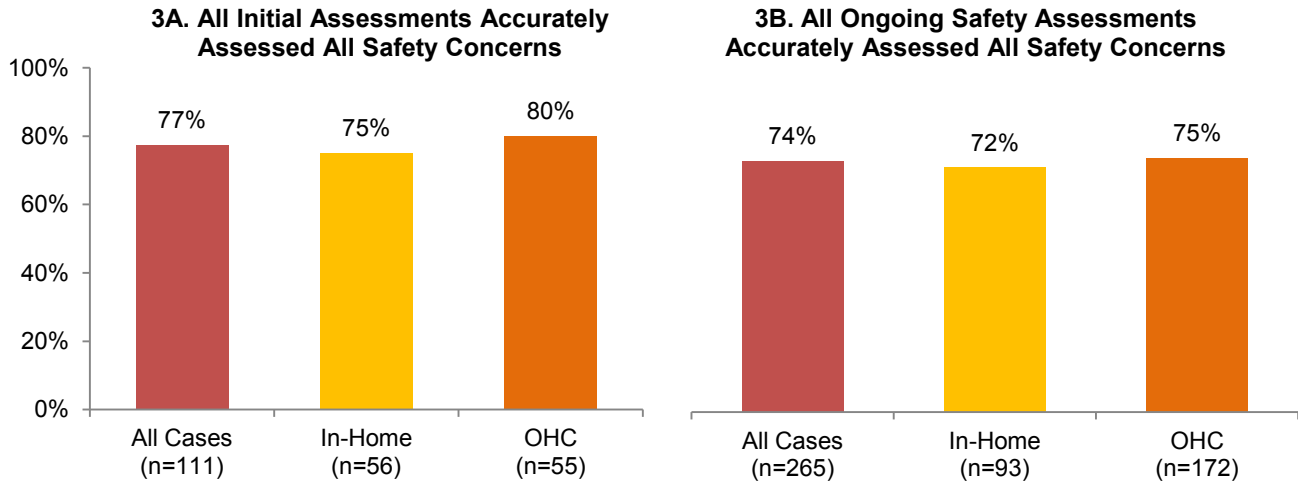
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 3:	**Risk and Safety Assessment and Management**	64%	36%	271	*90%*

Item 3 rates the agency's efforts to assess and address safety concerns related to children at home or in out-of-home care. Safety assessment, present danger assessment, protective planning, safety analysis, safety planning, and the management of child safety occur in every aspect of CPS involvement with a family. Therefore, all cases are assessed for Item 3.

If the agency completed all required assessments and plans (for the target child in out-of-home care and/or any children remaining in the home) and did not leave any safety concerns unaddressed, the case receives a *Strength*. Depending on the case type and events during the period under review, this could include formal assessments like Confirming Safe Environments (CSE), Family Interaction Plan (FIP), or Safety Analysis and Plan (SAP). Overall, 64% of cases received a *Strength* rating for Item 3.

The following figures show the performance of the cases reviewed on the specific components that make up the rating for Item 3. Figure 3 shows Item 3A and 3B relating to safety assessments carried out by the agency during the period under review. The number of cases applicable for each individual question (in parentheses) varies based on the safety intervention responsibilities that coincided with the period under review for each specific case. For example, if there was no Initial Assessment conducted during the period under review, the case was not applicable for Item 3A.

Figure 3: Initial and Ongoing Safety Assessments During the Period Under Review



In assessing this item, reviewers were asked to examine several areas of safety intervention practice and indicate if any unaddressed safety concerns or other safety-related issues occurred during the period under review. While reviewers may have indicated that such issues were present during the PUR, this does not mean that children were left in unsafe situations, rather that certain standards (per the CFSR ORSI and/or Wisconsin Child Welfare Policies and Standards) were not met in an ideal or timely manner per documentation in the case record. Additionally, reviewers had a set protocol to follow if they found a child to be unsafe during the course of the review (see Appendix 3).

In addressing Item 3A, reviewers had to indicate the following related to allegations of maltreatment during the period under review:

- There were maltreatment allegations about the family that were never formally reported or investigated/assessed (occurred in 35 cases, results not shown)
- There were maltreatment allegations that were not substantiated despite evidence that would support substantiation (occurred in 7 cases, not shown)

Figure 4 shows Item 3C, which covers safety plans created during the period under review. If there were no safety concerns present (i.e., no safety plan needed) during the period under review, the case was not applicable for this question. In a total of 58% (69) of the applicable cases, all safety plans developed by the local agency during the period under review were appropriate and updated as needed during the entire period under review.

Figure 4. Safety Plans During the Period Under Review

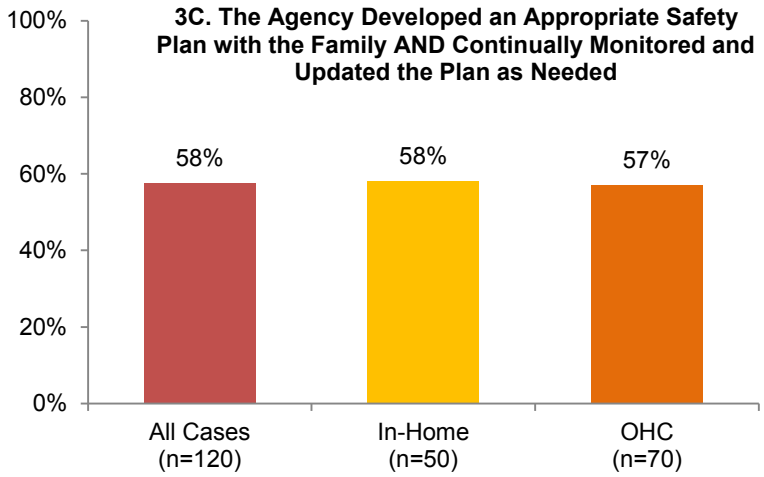
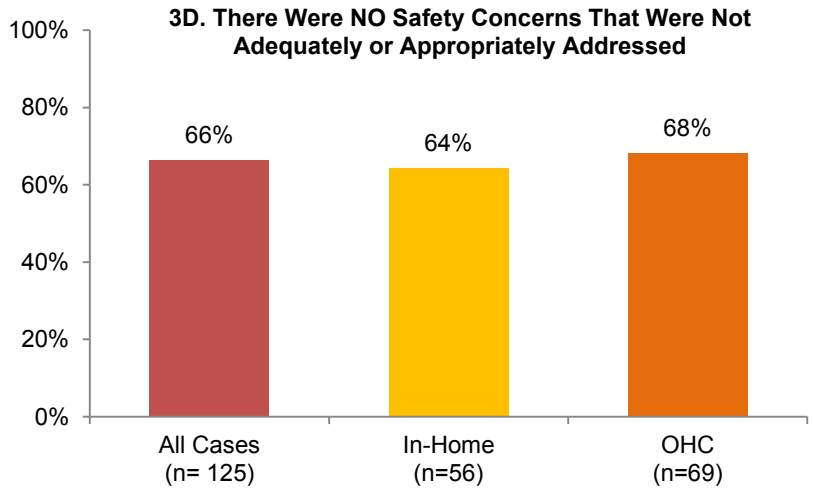


Figure 5 shows Item 3D, which covers identified safety concerns pertaining to the target child in out-of-home care and/or any children in the family remaining in the home. If there were no safety issues during the period under review, the case was not applicable for this question. In a total of 66% (83) of applicable cases, the local agency adequately and appropriately addressed all safety concerns during the entire period under review.

Figure 5: Safety Concerns During the Period Under Review



In addressing Item 3D, reviewers indicated any safety-related incidents that occurred during the period under review that were not adequately addressed by the agency. They included:

- Case was closed while significant safety concerns that were not adequately addressed still existed in the home (n=11)
- Recurring maltreatment[16] (n=3)
- Recurring safety concerns[17] (n=1)
- Other safety-related incidents[18] not adequately addressed by the agency (n=25)

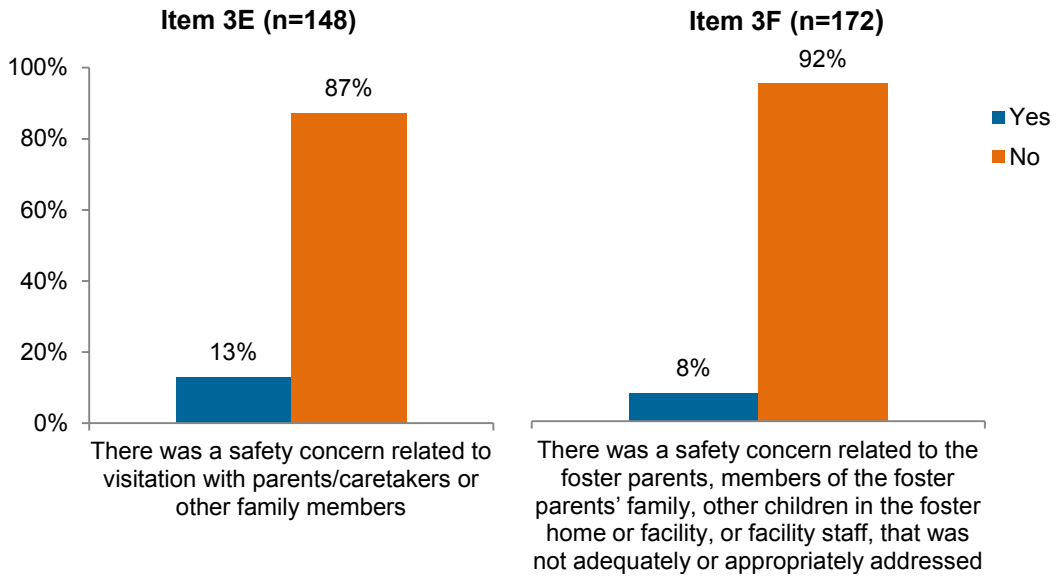
[16] The CFSR OSRI defines recurring maltreatment as follows: "There was at least one substantiated or indicated maltreatment report on any child in the family during the period under review AND there was another substantiated report within a 6-month period before or after that report **that involved the same or similar circumstances**" (*Child and Family Services Reviews Onsite Review Instrument*, January 2016, p. 17).

[17] The CFSR OSRI defines recurring safety concerns as follows: "There was at least one maltreatment report involving any child in the family during the period under review that was handled by an alternative response and resulted in opening the case for services to address safety concerns AND there was at least one additional maltreatment report within a 6-month period before or after that report that was handled by an alternative response and resulted in a decision to open the case for services to address **the same or similar safety concerns**" (*Child and Family Services Reviews Onsite Review Instrument*, January 2016, p.17).

[18] Per reviewers' comments, these incidents were largely related to re-referrals and parental substance abuse.

Items 3E and 3F relate to safety concerns in out-of-home care cases only. Figure 6 shows those results. Note that for Item 3E, the case was not applicable if the target child in OHC was not able to have visits with his or her parents.

Figure 6. Safety Concerns in OHC Cases During the Period Under Review



In addressing Item 3E, reviewers indicated if there were safety concerns related to visitation, specifically if the following occurred during the period under review:

- Unsupervised visitation was allowed when it was not appropriate (n=9)
- Sufficient monitoring of visitation by parents/caretakers or other family members was not ensured (n=8)
- Visitation was court-ordered despite safety concerns that could not be controlled with supervision (did not occur; n=0)
- Other safety concerns that existed with visitation (n=5)

In addressing Item 3F, reviewers indicated if safety concerns existed for any OHC care placement during the period under review. They included:

- The child's placement presented other risks to the child that are not being addressed, even though no allegation was made and no critical incident reports were filed (n=7)
- A critical incident report or other major issue relevant to noncompliance by foster parents or facility staff that could potentially make the child unsafe, and the agency could have prevented it or did not provide an adequate response after it occurred (n=1)
- Reviewer discovered that there are safety concerns related to the child in the foster home of which the agency is unaware because of inadequate monitoring (n=1)
- A substantiated allegation of maltreatment of the child by a foster parent (including a relative foster parent) or facility staff member that could have been prevented if the agency had taken appropriate actions (did not occur; n=0)
- Other safety concerns that existed with the child's foster placement (n=7)

Permanency Outcomes

Permanency Outcome 1: Children Have Permanency and Stability in Their Living Situations

Permanency Outcome 1 is based on the ratings for Items 4, 5, and 6. The purpose of assessment is to determine whether (1) the child in out-of-home care is in a stable placement (and that any placement changes were in his or her best interests); (2) appropriate permanency goals were established in a timely manner; and (3) concerted efforts were made, or are being made, to achieve those goals. Permanency Outcome 1 was *Substantially Achieved* in 34% of cases. The outcome was *Partially Achieved* in 60% of cases and *Not Achieved* in 6%.

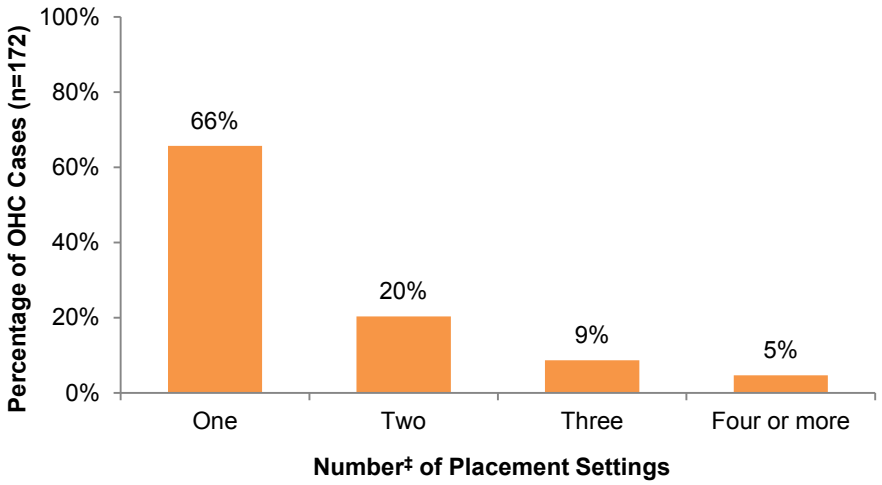
Permanency Outcome 1, Item 4

		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 4:	**Stability of Foster Care Placement**	82%	18%	172	*90%*

Item 4 rates the stability of out-of-home care placements through review of placement setting changes that occurred during the period under review. All OHC cases are assessed for this item. Cases were rated as a *Strength* if the current or most recent placement was found to be stable and any placement setting changes that occurred were planned by the agency in order to meet the child's needs and case goals. As shown above, 82% of cases received a *Strength* rating.

Figure 7 shows the number of placement settings in cases reviewed. Children in most cases (113 of 172, or approximately 66%) were in one setting for the entire PUR, meaning they experienced no placement changes. There were 35 children who were placed in two settings during the PUR.

Figure 7: Placement Settings During the Period Under Review



‡ *Note:* one case had 0 placement settings because of missing status at time of review. The maximum number of placement settings during the PUR was 5 (i.e., 4 placement changes).

Permanency Outcome 1, Item 5

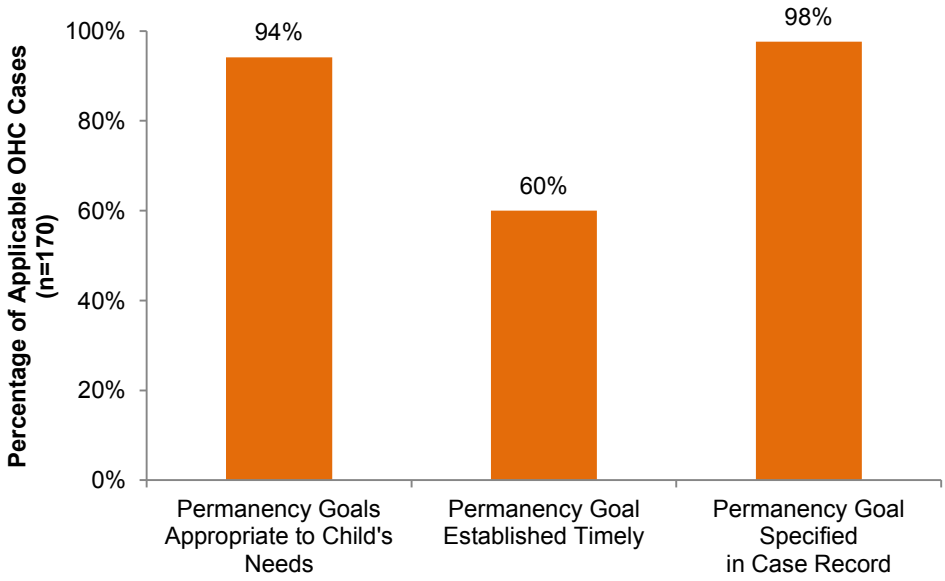
	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 5: Permanency Goal for Child	54%	46%	170	*90%*

Item 5 rates the timeliness and appropriateness of permanency goals. All permanency plans created during the period under review are considered, as well as any plan created before the PUR began if it was still active at the time of the review. All OHC cases where the target child has been in care for more than 60 days are assessed. Out of 172 OHC cases, 170 were assessed for this item.

For Item 5, 54% of cases were rated as a *Strength.* In order to receive a *Strength* rating, all permanency goals must have been documented in the case file, established timely, and deemed appropriate to meet the child's needs. If ASFA applied, TPR had to be filed in a timely manner. If there were exceptions to the ASFA rules, they needed to be documented.

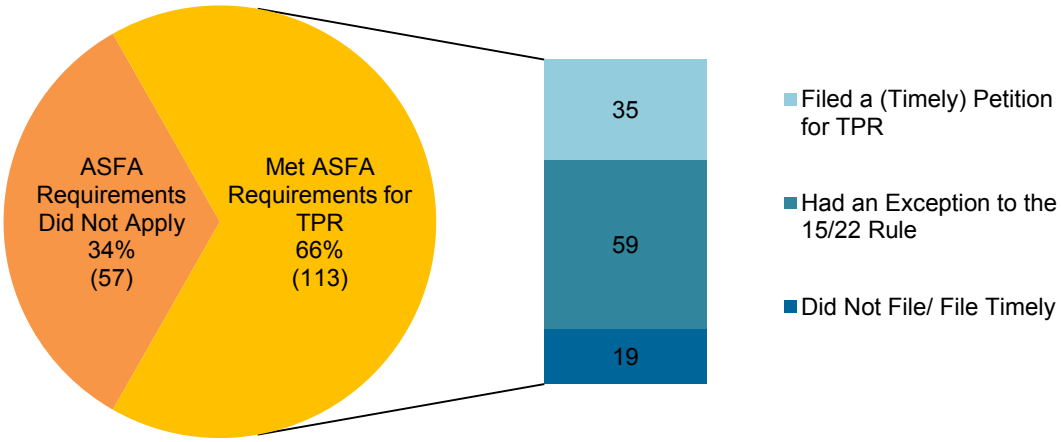
As shown in Figure 8, 94% of cases reviewed (160 of 170) had permanency plans in effect during the period under review that were appropriate to meet the child's needs. The permanency goal was specified in the case file in 98% (166) of cases; 60% of cases had a permanency goal that was established in a timely manner.

Figure 8: Setting Permanency Goals



Of the 170 applicable children in out-of-home care, 66% (113) met Adoption and Safe Families Act (ASFA) criteria for termination of parental rights (TPR), either because they had been in care for 15 of the most recent 22 months (110 cases) or they met other criteria (3 cases). In 31% (35) of the cases meeting AFSA criteria for TPR, the agency filed or joined a TPR petition in a timely manner. In 52% (59) of those cases, exceptions to ASFA applied, as shown in Figure 9 and Table 5.

Figure 9: Adoption and Safe Families Act Requirements



The following table shows the specific AFSA exceptions to the 15/22 rule for cases reviewed.

Table 5: Exceptions to Requirements of the Adoption and Safe Families Act

Exceptions	Applicable OHC Cases (n=59)
At the option of the state, the child is being cared for by a relative at the 15/22-month time frame.	58% (34)
The agency documented in the case plan a compelling reason for determining that termination of parental rights would not be in the best interests of the child.	39% (23)
The state has not provided to the family the services that the state deemed necessary for the safe return of the child to the child's home.	3% (2)

Permanency Outcome 1, Item 6

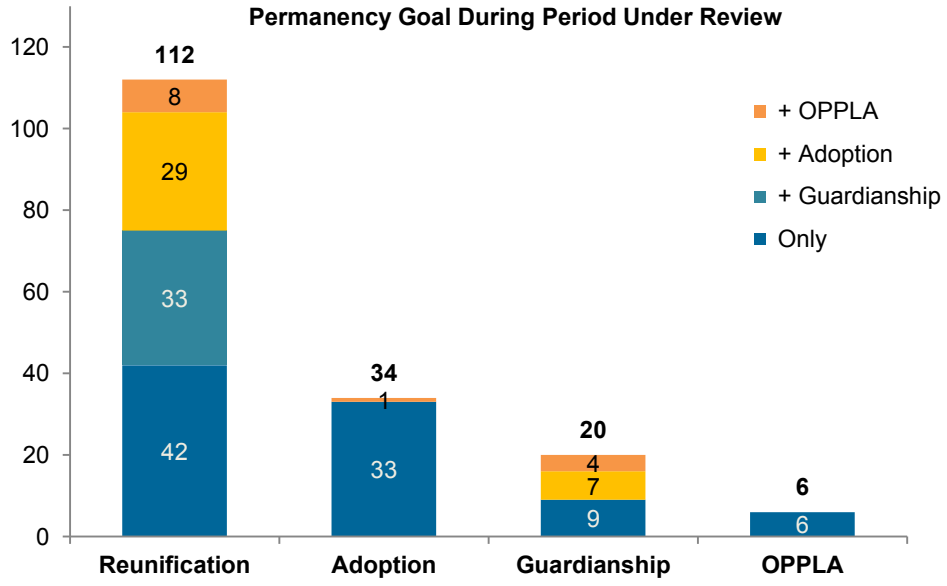
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 6:	**Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement (OPPLA)**	66%	34%	172	*90%*

Item 6 looks at the efforts made during the period under review to achieve permanency goals set for the target child. All OHC cases are assessed for this item.

In order to receive a *Strength* rating, the permanency goal has to be achieved within the timeframes suggested by the federal government—12 months for reunification, 18 months for guardianship, and 24 months for adoption—unless there are particular circumstances justifying a delay (such as disruption in a pre-adoptive placement "despite concerted efforts on the part of the agency to support it"[19]). For cases where OPPLA is the only goal, the local agency must "make concerted efforts to place the child in a living arrangement that can be considered permanent until discharge from foster care"[20] and complete formal steps to make the arrangement permanent, such as an Independent Living case plan. As shown above, 66% of cases received a *Strength* rating for Item 6.

Figure 10 shows the permanency goals for the target children in the OHC cases reviewed. The most common was a single goal of reunification (42 cases or 24%), followed by a single goal of adoption, as well as concurrent goals of reunification and guardianship (33 cases or 19%).

Figure 10: Permanency Goals



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[19] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.34)

[20] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.35)

Permanency Outcome 2: The Continuity of Family Relationships and Connections is Preserved for Children

Permanency Outcome 2 is composed of five items. The purpose of assessment is to determine whether concerted efforts were made to ensure that siblings in out-of-home care are placed together and children are placed with relatives whenever possible. It is also to determine whether concerted efforts were made to ensure: (1) sufficient visitation between the child in care and his or her mother, father, and siblings; (2) the child's connections to his or her extended family and community are maintained; and (3) positive relationships between the child in care and his or her mother and father is promoted/supported.

Based on the ratings for Items 7 through 11, Permanency Outcome 2 was *Substantially Achieved* in 56% of cases. The outcome was *Partially Achieved* in 38% of cases and *Not Achieved* in 5%.

Permanency Outcome 2, Item 7

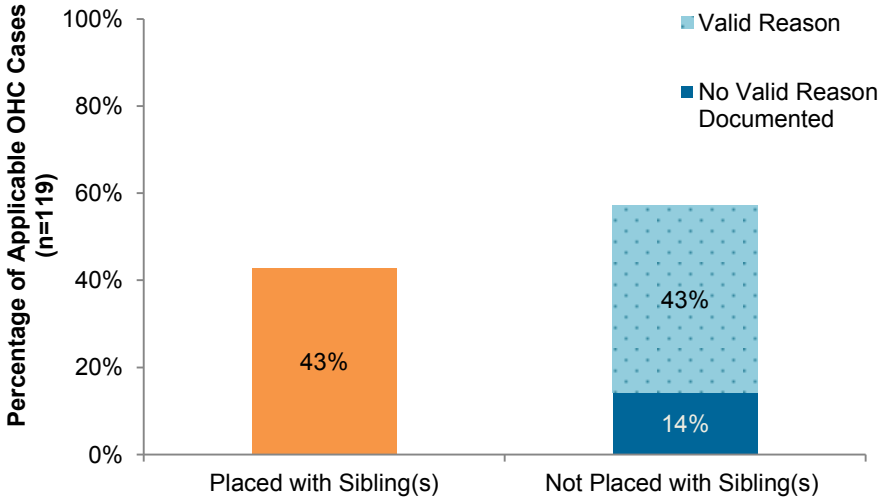
	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 7: Placement With Siblings	86%	14%	119	*90%*

Item 7 measures efforts to keep siblings together in out-of-home care placement. Cases where the target child has one or more siblings in out-of-home care during the period under review are assessed for this item. Out of 172 total OHC cases, 119 cases were assessed.

In order to receive a strength rating, children must be placed with sibling(s) during the entire period under review, unless there is a valid reason for their separation. As shown above, 86% of cases were rated as a *Strength.*

Figure 11 shows that 43% (51) of the 119 applicable children were placed with their sibling(s) during the entire period under review, meaning that 57% (68) were not. However, in the majority of cases where the child was not placed with siblings (51 out of 68 cases, or 75%), there was a valid reason, such as it was not in their best interest or the child's level of need exceeded the level of care.

Figure 11: Placement with Siblings in Out-of-Home Care



Permanency Outcome 2, Item 8

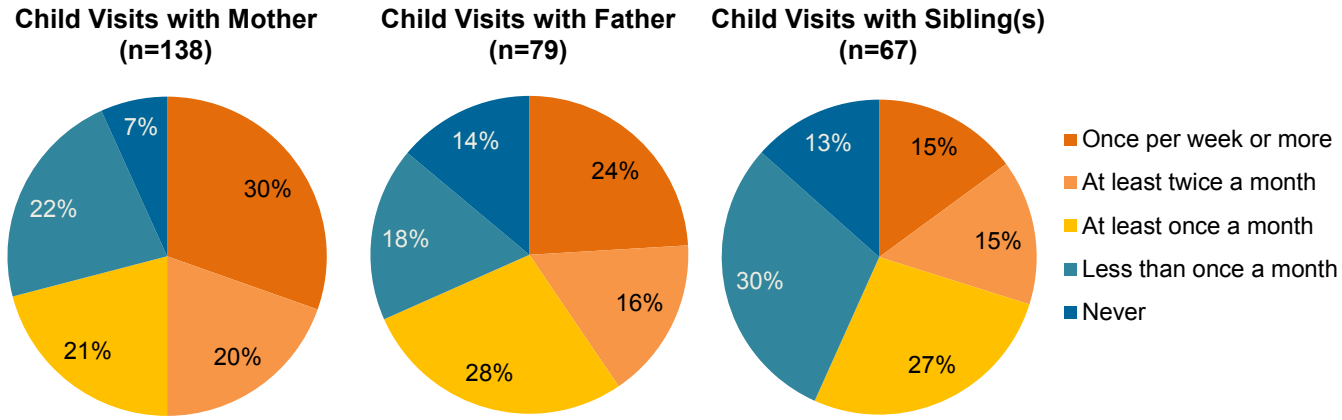
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 8:	**Visiting with Parents and Siblings in Foster Care**	57%	43%	157	*90%*

Item 8 rates the agency's efforts to ensure visits (or other forms of communication) between the child in care and his or her mother and father, as well as other siblings placed in out-of-home care. Specifically, the item measures whether the frequency and quality of visits were sufficient to "promote continuity in the child's relationship with these close family members."[21] Cases are excluded if parental rights were terminated during the entire period under review, the whereabouts of the mother or father were unknown, and/or it was documented that it was not in the child's best interest to have visits. A total of 157 cases were assessed for this item.

In order to receive a *Strength* rating for Item 8, the target child in out-of-home care must have quality visits with his or her mother and/or father as well as other siblings in foster care (where applicable[22]) with a frequency sufficient to maintain or promote the relationship. In total, 57% of cases received a *Strength* and 43% were an *Area Needing Improvement*.

Figure 12 shows the frequency with which children in out-of-home care met with their caregivers and siblings. For example, in 30% of applicable cases, the child saw the maternal caregiver with whom he or she was to be reunified once per week or more during the period under review.

Figure 12: Child Visits with Parents and Siblings in Out-of-Home Care



[21] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.40)

[22] Note that the CFSR OSRI generally defines "Mother" and "Father" as the parents/caregivers from whom the child was removed and with whom the agency is working toward reunification (which may include individuals who do not meet the legal definition of a mother and father).

Apart from the actual frequency with which visits occur, Item 8 measures efforts to ensure that the frequency is sufficient to maintain relationships given the circumstances of the child and family. For example, Table 6 shows that that the local agency had documented efforts to ensure frequent visits (regardless of the actual frequency with which they occurred) in 73% of applicable cases.

Table 6. Frequency of Child's Visits with Family Members

	Mother (n=138)	Father (n=79)	Sibling(s) (n=67)
The agency made concerted efforts to ensure that visitation was of sufficient frequency to maintain the relationship	73% (101)	70% (55)	55% (37)

This item rating also encompasses the quality of visits (e.g., if they occurred in a comfortable atmosphere, were of an appropriate duration, etc.). If there were no visits during the period under review (i.e., "Never" in Figure 12), this question is not applicable.

Table 7. Quality of Child's Visits with Family Members

	Mother (n=137)	Father (n=68)	Sibling(s) (n=66)
The agency made concerted efforts to ensure that the quality of visitation was sufficient to maintain the relationship	82% (105)	74% (50)	65% (43)

Permanency Outcome 2, Item 9

	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 9: Preserving Connections	75%	25%	167	*90%*

Item 9 rates the agency's efforts to "maintain the child's connections to his or her neighborhood, community, faith, extended family, Tribe, school, and friends."[23] In cases where the target child is eligible for protections under the Wisconsin Indian Child Welfare Act (WICWA), the item also measures the local agency's attempts to notify the tribe and follow ICWA placement preferences. [24]

All OHC cases are assessed for this item, except where there are rare circumstances "such as an abandoned infant where the agency has no information about the child's extended family or connections."[25] A total of 167 cases were assessed.

In order to receive a *Strength* rating in Item 9 the local agency must demonstrate efforts to maintain the child's important connections. (The agency must also notify the Tribe in a timely manner and follow placement preferences in cases subject to WICWA.) As shown above, 75% of cases were rated as a *Strength*.

Table 8 shows agency efforts to maintain important connections for the child in out-of-home care. Such connections can include siblings who are not in out-of-home care, extended family members (e.g., grandparents, aunts, uncles, cousins), connections to the school where he or she was enrolled (i.e., remaining in the same school if it is in his or her best interest), or any other important connection the child had prior to placement in out-of-home care.

Table 8: Maintaining Connections for Children in Out-of-Home Care

	Applicable OHC Cases (n=167)
The agency made concerted efforts to maintain the child's important connections	78% (130)

[23] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.45)

[24] The Indian Child Welfare Act (ICWA) is a federal law enacted by Congress in 1978 with the intent to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). With the intent to clarify the law and improve compliance in Wisconsin, ICWA was signed into state law on December 7, 2009. This state law is known as the Wisconsin Indian Child Welfare act or WICWA.

[25] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.45)

Table 9 shows the results for sufficient inquiry, timely notification, and concerted efforts to place the child in accordance with ICWA placement preferences in the cases of children subject to WICWA. It is worth noting, however, that there were very few ICWA-eligible children in the sample (n=10).

Table 9: Indian Child Welfare Act

	Yes		No	
	%	N	%	N
Sufficient inquiry to determine whether the child may be a member of, or eligible for membership in, a federally recognized Indian Tribe	72%	(120)	28%	(47)
Tribe provided timely notification of its right to intervene in any state court proceedings seeking an involuntary foster care placement or termination of parental rights	50%	(5)	50%	(5)
Concerted efforts made to place child in accordance with Indian Child Welfare Act placement preferences	67%	(6)	33%	(3)

Permanency Outcome 2, Item 10

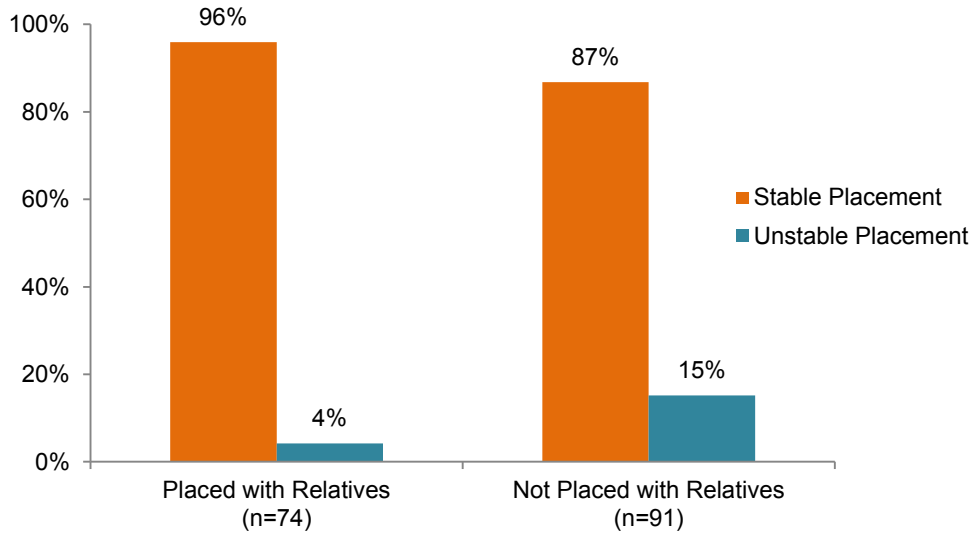
	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 10: Relative Placement	62%	38%	165	*90%*

Item 10 examines agency efforts to place children with relatives when possible and appropriate. All OHC cases are assessed for this item, except those in which the child has specialized placement needs or "situations such as abandonment in which the identity of both parents and all relatives remains unknown despite documented concerted efforts to identify them."[26] Removing these cases left a total of 165 cases.

If the child was placed with a relative during the entire period under review then the case is rated as a *Strength*. Cases also receive a *Strength* rating if the child was not placed with a relative but the agency demonstrated concerted efforts to find relatives (with the result that they were ruled out as potential placement resources). As shown above, 62% of cases received a *Strength* rating for Item 10.

During the period under review, the current or most recent placement was with a relative for 45% (74) of the target children in the 165 cases assessed; 55% (91) were not placed with a relative. As shown in Figure 13, reviewers indicated that 96% of relative placements (71 out of the 74) were "stable and appropriate to the child's needs."[27]

Figure 13. Relative Placement and Placement Stability‡



‡*Note:* A cross tabulation of Item 4 data and Item 10 data was used to derive the number of "unstable" placements for those cases where the child was not placed with a relative.

[26] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.48)
[27] *Ibid.*

As noted above, this item also takes into account efforts made by the local agency to find relative placements in cases where the child was not placed with a relative. Table 10 shows those results. For the reasons stated previously, some cases were not applicable for the mother and/or the father.

Table 10: Documented Efforts at Finding Relatives for Potential Placement

	Maternal Relatives (n=84)	Paternal Relatives (n=79)
The agency made concerted efforts to identify, locate, inform, and evaluate relatives as potential placement resources	50% (42)	32% (25)

Permanency Outcome 2, Item 11

		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 11:	**Relationship of Child in Care with Parents**	67%	33%	147	*90%*

Item 11 measures agency efforts to support positive relationships between the child in foster care and his or her primary caregivers (through activities other than arranging for visitation). All OHC cases are assessed for this item, except in circumstances where it would not be possible or appropriate for the child in care to develop/maintain a relationship with his or her parents. Removing these cases[28] left a total of 147 cases.

Cases receive a *Strength* rating if it was documented how concerted efforts were made to support the child's relationship with his or her mother and/or father (where applicable). For Item 11, 67% of cases were rated as a *Strength.*

Table 11 shows the overall results. For the reasons stated previously, some cases were not applicable for assessment of this item for the mother and/or the father. Out of 138 applicable cases, local agencies had documented evidence of concerted efforts to support a relationship with the child's mother 74% of the time (102 cases). Out of 76 applicable cases, local agencies demonstrated concerted efforts for fathers 68% of the time (52 cases).

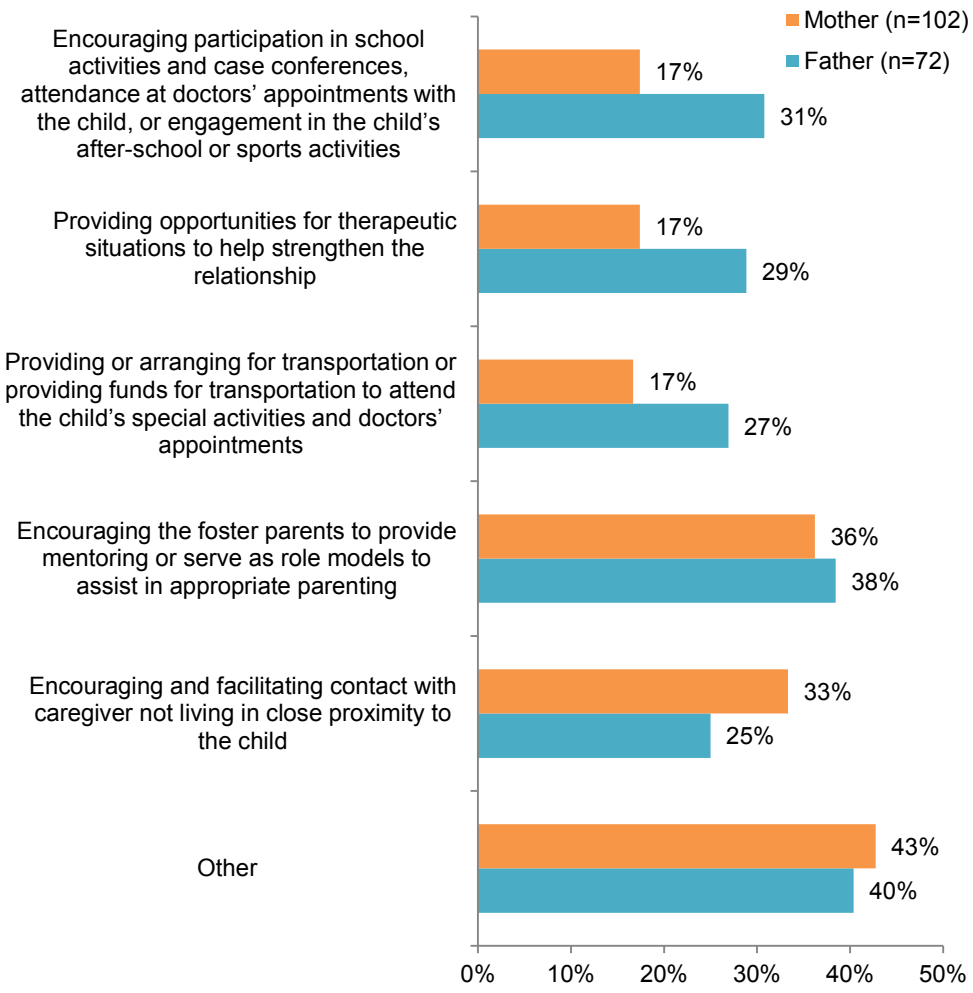
Table 11: Documented Efforts to Support the Parent-Child Relationship

	Mother (n=138)	**Father (n=76)**
The agency made concerted efforts to promote, support, and otherwise maintain a positive and nurturing relationship	74% (102)	68% (52)

Figure 14 shows the many ways in which local agencies made efforts to promote parental relationships for the children in care. For example, of the cases where efforts were documented, 17% encouraged the mother to participate in the child's school activities or doctor's appointments. (Note that aggregate percentages exceed 100% because agencies often engaged in more than one effort at a time.)

[28] The case is not assessed for Item 11 if any of the following apply: the parental rights for both parents remained terminated during the entire period under review; the child was abandoned and neither parent could be located; the whereabouts of both parents were not known during the entire period under review; contact with both parents was considered to be not in the child's best interest and this was documented in the case file; during the entire period under review, both parents were deceased; the only parent(s) being assessed do not meet the definition for Mother/Father.

Figure 14. Efforts to Support Parent-Child Relationship



Well-Being Outcomes

Well-Being Outcome 1: Families Have Enhanced Capacity to Provide for Their Children's Needs

The first well-being outcome is composed of four items. The purpose of assessment is to determine whether the agency made concerted efforts to: (1) assess the needs of the children, parents, and foster parents and provide appropriate services when needed; (2) involve the child and family in case planning; and (3) ensure that caseworker visitation with the child and parents is of sufficient frequency and quality to promote achievement of case goals.

Overall, based on the rating for items 12 through 15, Well-Being Outcome 1 was *Substantially Achieved* in 46% of cases. The outcome was *Partially Achieved* in 39% of cases and *Not Achieved* in 14%.

Well-Being Outcome 1, Item 12

		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 12:	**Needs and Services of Child, Parents, and Foster Parents**	**52%**	**48%**	271	*90%*
Sub-Item 12A:	**Needs Assessment and Services to Children**	**80%**	**20%**	271	*90%*
Sub-Item 12B:	**Needs Assessment and Services to Parents**	**59%**	**42%**	253	*90%*
Sub-Item 12C:	**Needs Assessment and Services to Foster Parents**	**85%**	**15%**	162	*90%*

Item 12 is divided into three sub-items which examine how agencies assess needs and provide or procure services to meet identified needs for children, parents, and foster or pre-adoptive parents (where applicable). Specifically, the item measures in all three areas whether the agency conducted a formal or informal assessment that accurately assessed needs and whether or not appropriate services were provided to meet those needs. (Note that health and educational needs for children are assessed separately in Items 16 through 18.)

All cases are assessed for Item 12, though some cases may be excluded from Sub-Item 12B if, during the entire period under review, certain circumstances pertaining the parents applied.[29] The same is true of Sub-Item 12C, where in-home cases are excluded, as well as some OHC cases.[30]

In order to receive a *Strength* for Item 12, each of the applicable sub-items must be rated as a *Strength*, meaning that the agency accurately assessed the individuals' needs AND provided appropriate services to meet any identified needs. As shown above, 52% of cases were rated as a *Strength* for this item, while 48% received an *Area Needing Improvement*.

[29] If any of the following apply (during the entire PUR), the case is not assessed for Sub-Item 12B: parental rights remained terminated; parent's whereabouts were not known; parents were deceased; it was documented in the case file that it was not in the child's best interest to involve the parent in case planning; the parent indicated that she/he did not want to be involved in the child's life and this was documented in the case file.

[30] All OHC cases are applicable for assessment of Sub-Item 12C, unless, during the entire PUR, the child was placed in a residential facility or similar placement and did not have foster parents.

Figures 15 and 16 show the results of the sub-items related to children and their parents by case type. For example, in 83% of cases, a comprehensive assessment was conducted that accurately gauged the child's needs (Figure 15). Appropriate services were provided in 79% of all applicable[31] cases to meet the specific needs identified for the child (Figure 16).

Figure 15. Comprehensive Needs Assessments Conducted for Children and Parents

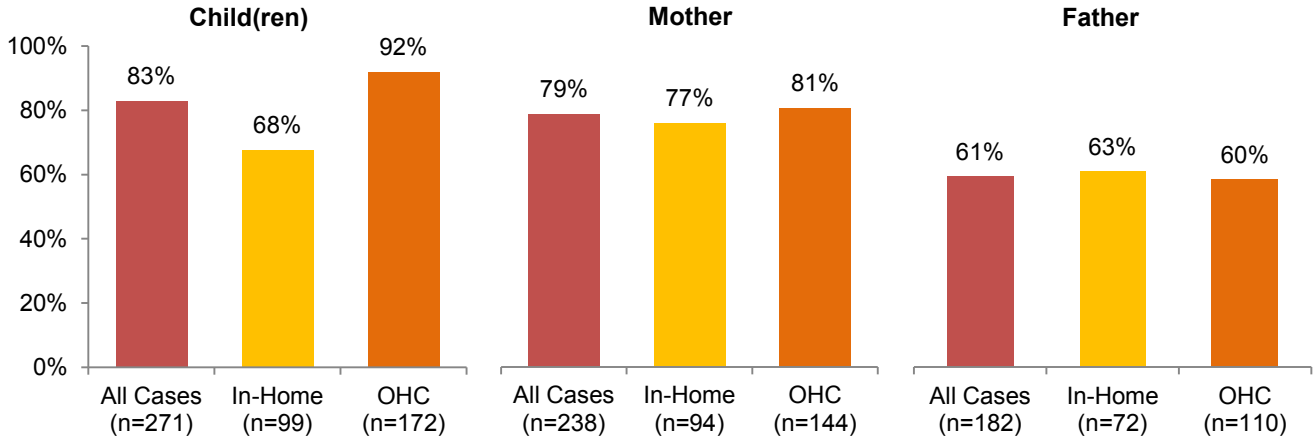
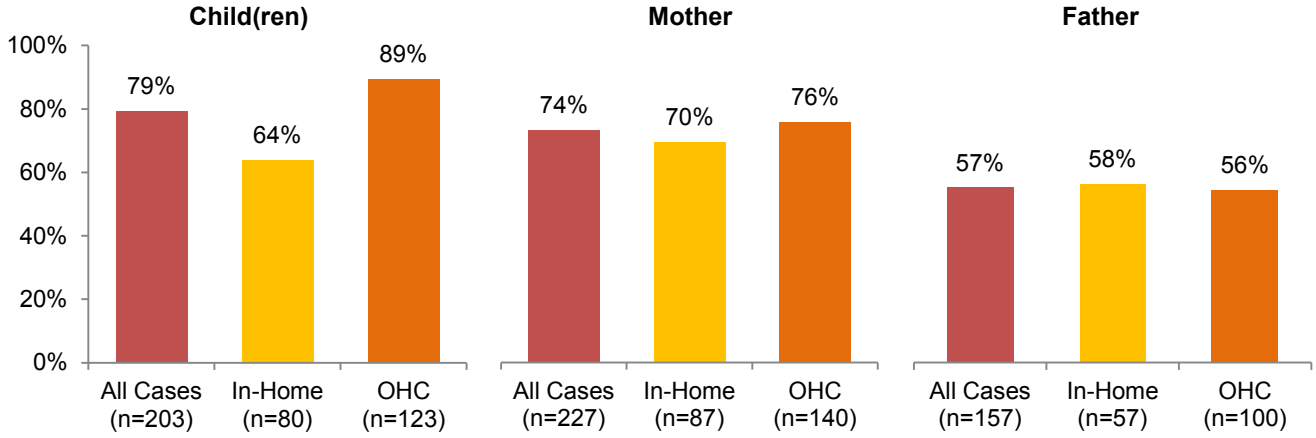


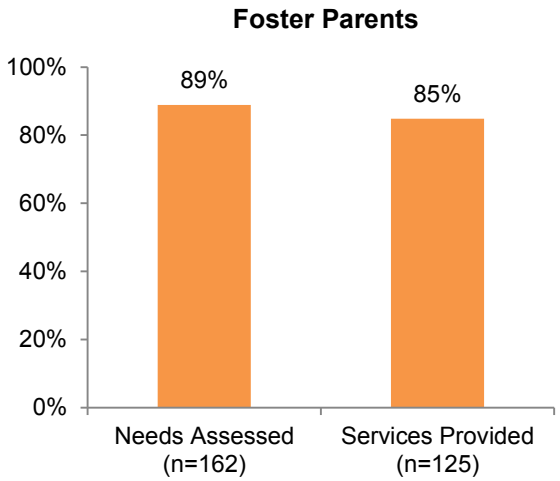
Figure 16. Services Provided to Meet Child and Parent Needs



[31] If an assessment was conducted and the result was that no service needs were identified (other than those related to education, physical health, and mental/behavioral health, which pertain to Items 16 through 18), then the question regarding provision of services is not applicable.

Figure 17 shows the results of Sub-Item 12C pertaining to foster parents. In 89% (144) of applicable OHC cases, the agency conducted a comprehensive needs assessment for the foster parents, and in 85% (206) they received services arranged for or provided by the agency to meet identified needs.

Figure 17. Needs Assessments and Services Provided to Foster Parents



Well-Being Outcome 1, Item 13

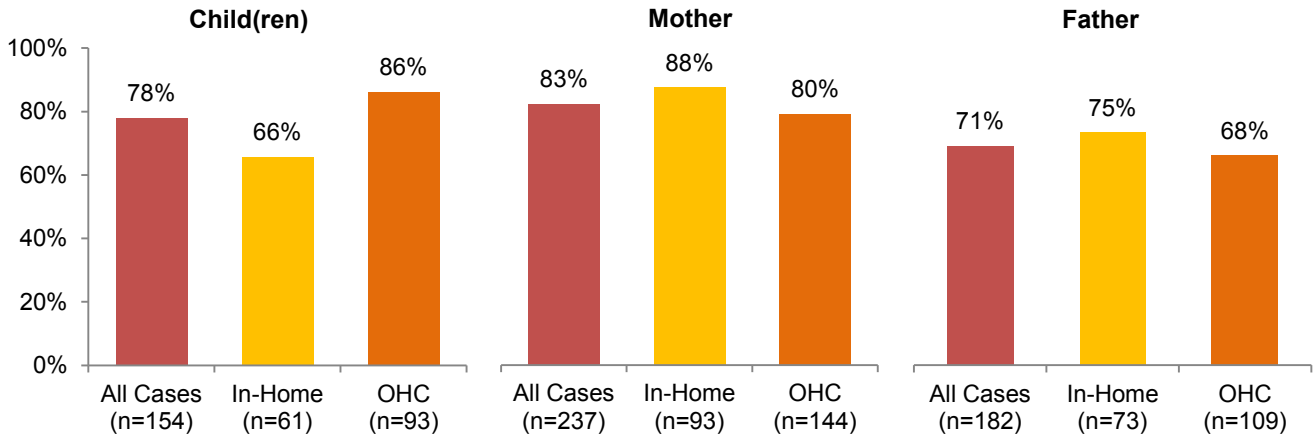
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 13:	**Child and Family Involvement in Case Planning**	67%	33%	264	*90%*

Item 13 measures concerted efforts to actively involve the child[32] and family[33] in case planning. All cases are assessed for Item 13, except for those involving children for whom participation in case planning is not developmentally appropriate, as well as other cases with certain circumstances pertaining to the mother and/or father.[34] A total of 264 cases were assessed for this item.

If the agency documented concerted efforts to engage the mother and/or father in case planning (where applicable), as well as the child (where developmentally appropriate), the case is rated as a *Strength.* Of cases reviewed, 67% were rated as a *Strength* and 33% were an *Area Needing Improvement*.

Figure 18 shows the results for this item by case type.

Figure 18. Documented Efforts Were Made to Involve Children and Their Parents in Case Planning



[32] "'Actively involved' means that the agency consulted with the child (as developmentally appropriate) regarding the child's goals and services, explained the plan and terms used in the plan in language that the child can understand, and included the child in periodic case planning meetings, particularly if any changes are being considered in the plan" (*Child and Family Services Reviews Onsite Review Instrument*, January 2016, p.66).

[33] "'Actively involved' means that the agency involved the mother or father in (1) identifying strengths and needs, (2) identifying services and service providers, (3) establishing goals in case plans, (4) evaluating progress toward goals, and (5) discussing the case plan" (*Child and Family Services Reviews Onsite Review Instrument*, January 2016, p.67).

[34] Similar to Item 12, if any of the following apply (during the entire PUR), the case is not assessed for this item: parental rights remained terminated; parent's whereabouts were not known; parents were deceased; it was documented in the case file that it was not in the child's best interest to involve the parent in case planning.

Well-Being Outcome 1, Item 14 and Item 15

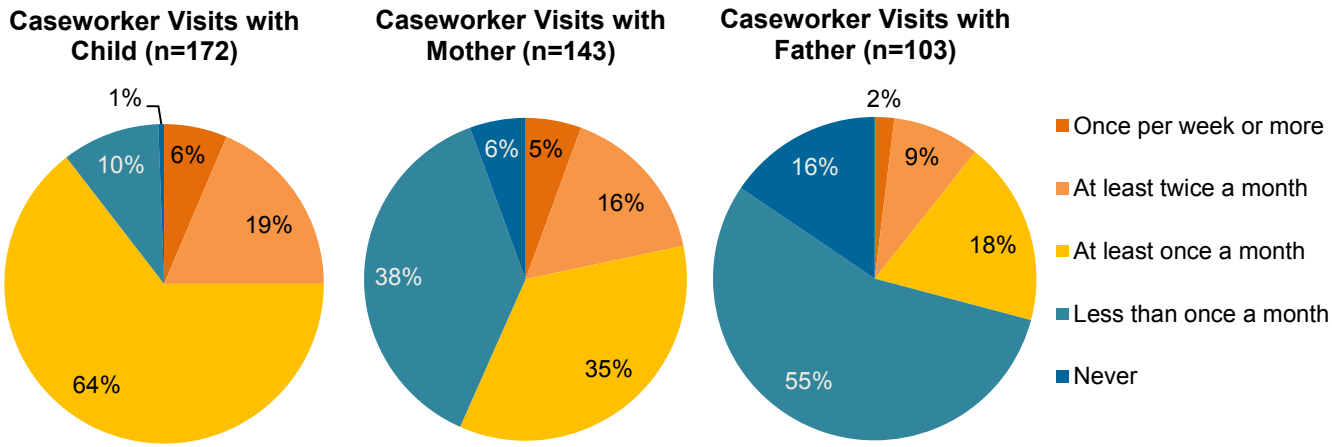
	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 14: Caseworker Visits With Child	69%	31%	271	*90%*
Item 15: Caseworker Visits With Parents	48%	52%	250	*90%*

Items 14 and 15 determine whether the frequency and quality of visits between caseworkers and the child(ren) in the case, as well as the mothers and fathers of the children, are sufficient to ensure child safety, permanency, and well-being, as well as to promote achievement of case goals. All cases are assessed for Item 14, whereas Item 15 excludes cases if certain circumstances apply to the parents.[35] A total of 250 cases were assessed for Item 15.

In order to receive a *Strength* rating, caseworkers must have quality visits with the child(ren) and their mother and/or father (where applicable) with sufficient frequency to promote achievement of case goals and to ensure safety, permanency, and well-being for the child(ren). As shown above, 69% of cases received a *Strength* for Item 14, and 48% received a *Strength* for Item 15.

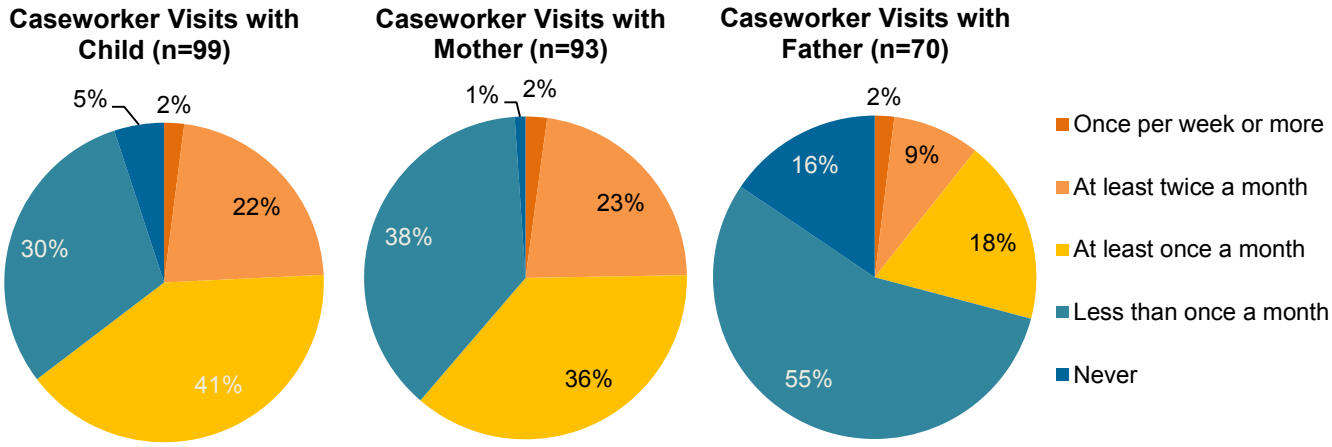
Figures 19 and 20 show the frequency with which caseworkers met with the children and their mothers and fathers, where applicable. For example, in 64% of OHC cases, the worker saw the child at least once per month, in 19% of cases at least twice per month, and in 6% of cases once per week or more.

Figure 19: Caseworker Visits with Child and Parents: OHC Cases



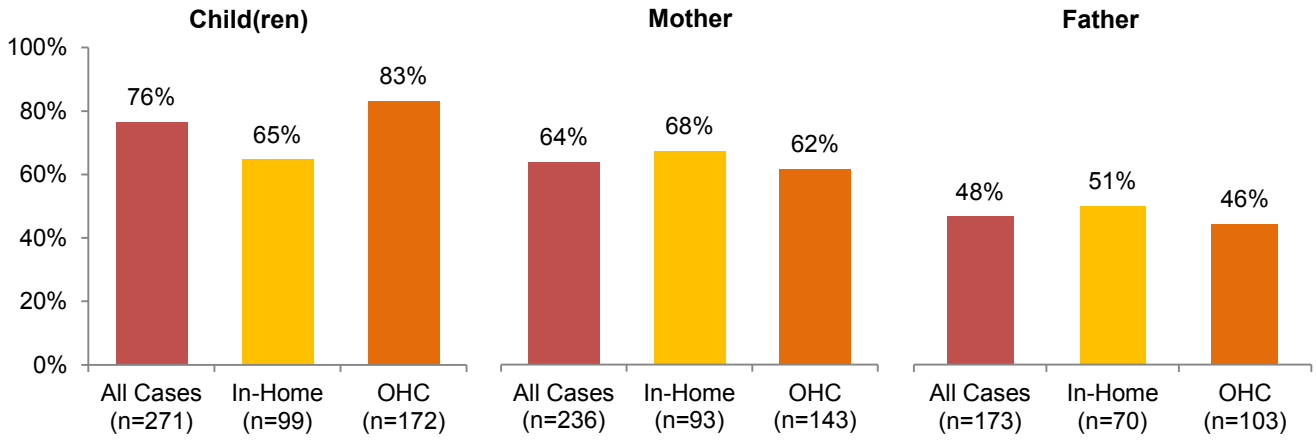
[35] As with Item 12, if any of the following apply (during the entire PUR), the case is not assessed for Item 14: parental rights remained terminated; parent's whereabouts were not known; parents were deceased; it was documented in the case file that it was not in the child's best interest to involve the parent in case planning; the parent indicated that she/he did not want to be involved in the child's life and this was documented in the case file.

Figure 20: Caseworker Visits with Child and Parents: In-Home Cases



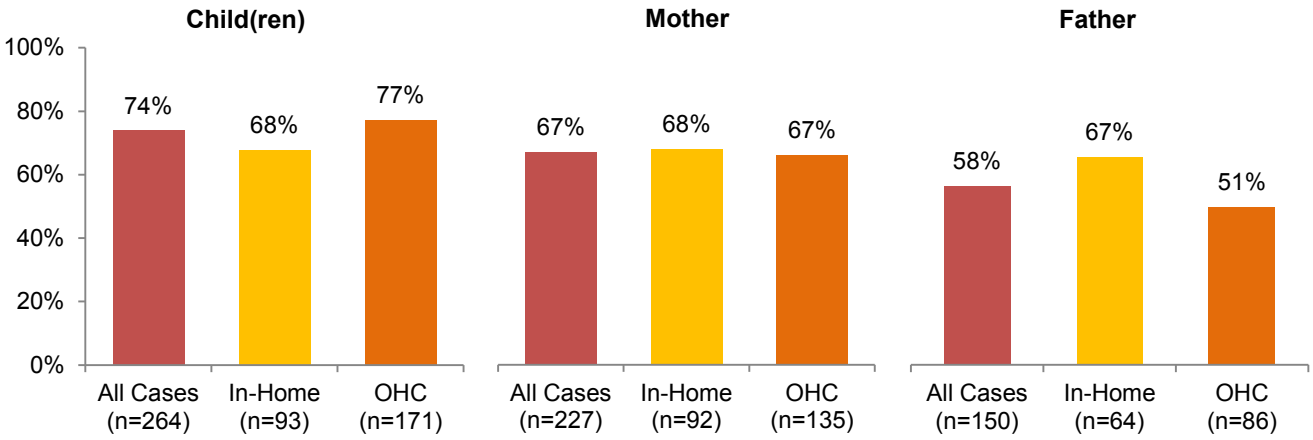
Apart from the actual frequency with which visits occur, Item 14 and Item 15 measure efforts to ensure that the frequency is sufficient to promote achievement of case goals and ensure child safety, permanency, and well-being. For example, Figure 21 shows that, the caseworker visited the child(ren) with enough frequency to ensure their safety and well-being in 76% of cases reviewed.

Figure 21. Sufficient Frequency of Caseworker Visits with Children and Parents



This item rating also encompasses the quality of visits (e.g., if they were of sufficient length to address key issues, the appropriateness of the location, etc.). If there were no visits during the period under review (i.e., "Never" in Figures 19 and 20), this question is not applicable. In 74% (195) of all cases, caseworker visits with the child(ren) were rated as quality per the OSRI criteria, as shown in Figure 22.

Figure 22. Sufficient Quality of Caseworker Visits with Children and Parents



Well-Being Outcome 2: Children Receive Appropriate Services to Meet Their Educational Needs

The purpose of Well-Being Outcome 2 is to "assess whether, during the period under review, the agency made concerted efforts to assess children's educational needs at the initial contact with the child (if the case was opened during the period under review) or on an ongoing basis (if the case was opened before the period under review), and whether identified needs were appropriately addressed in case planning and case management activities."[36] This outcome was *Substantially Achieved* in 87% of cases. The outcome was *Partially Achieved* in 2% of cases and *Not Achieved* in 11%.

Well-Being Outcome 2, Item 16

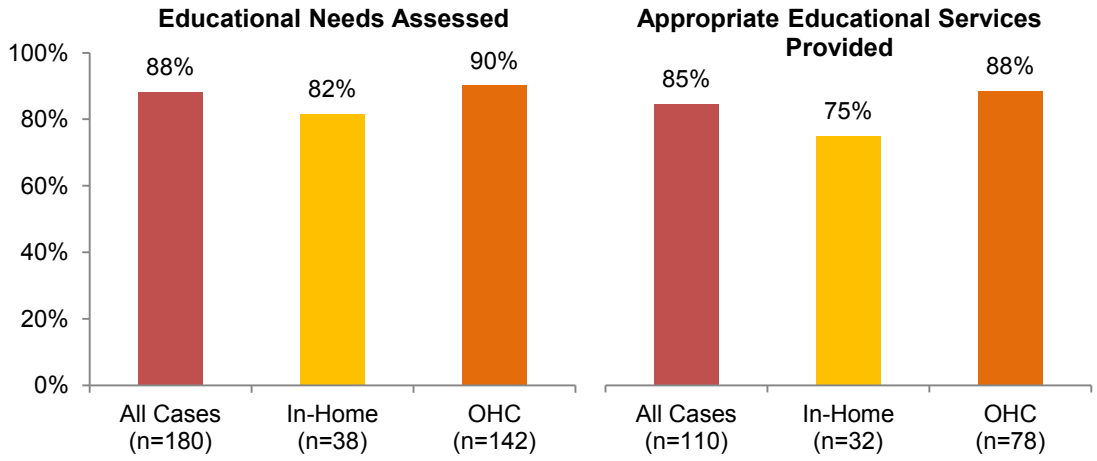
	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 16: Educational Needs of the Child	88%	12%	180	*95%*

Item 16 measures concerted efforts by the agency to assess the children's educational needs and whether appropriate services were provided to meet any needs identified. Examples of such services include helping the child to be assessed for and obtain an Individualized Education Plan (IEP), a Behavioral Intervention Plan (BIP), tutoring, restrictive classroom, additional time for taking tests, etc. It is worth noting that in-home cases are only assessed for this item if education was the reason for the local agency's involvement (e.g., truancy).

In order to receive a *Strength* rating, there must be documented evidence of the agency's efforts to accurately assess the child's educational needs as well as concerted efforts to address any identified needs through appropriate services (where applicable). For Item 16, 88% of cases were rated as a *Strength*.

Figure 23 shows the results of this item by case type. In 88% of reviewed cases, educational needs were accurately assessed. In 85% of applicable cases, appropriate services were provided.

Figure 23. Assessment of Children's Educational Needs and Services Provided



[36] *Child and Family Services Reviews Onsite Review Instrument*, January 2016 (p.76)

Well-Being Outcome 3: Children Receive Adequate Services to Meet Their Physical and Mental Health Needs

The final well-being outcome determines whether the agency addressed the physical and mental health needs of the children. Based on the ratings for Item 17 and 18, Well-Being Outcome 3 was *Substantially Achieved* in 59% of cases. The outcome was *Partially Achieved* in 16% of cases and *Not Achieved* in 25%.

Well-Being Outcome 3, Item 17

	Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 17: Physical Health of the Child	61%	39%	205	*90%*

Item 17 examines whether or not the agency addressed the physical health needs (including dental needs) of the children. Similar to Item 16, in-home cases are only applicable if physical health needs of the child(ren) were the reason for agency involvement. A total of 205 cases were assessed for this item.

Item 17 is rated as a *Strength* if is documented evidence that accurate needs assessments were conducted and the agency made efforts to provide needed services (where applicable), as well as appropriate oversight of prescription drug use for children in out-of-home care (where applicable). As shown above, 61% of cases received a *Strength* rating for Item 17.

Figures 24 and 25 show the results for this item. For example, the agency accurately assessed for the child's physical health needs in 79% of applicable cases.

Figure 24. Assessment of Children's Health Needs and Services Provided

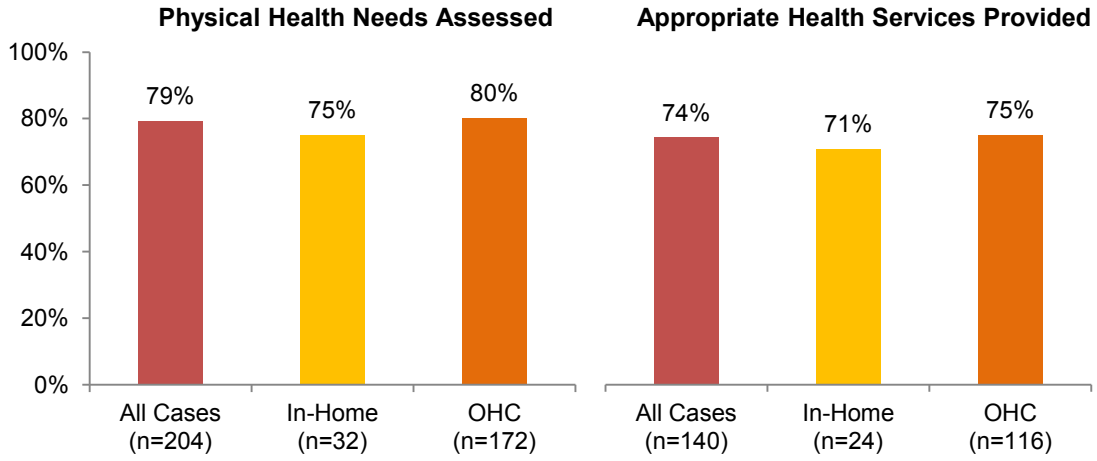
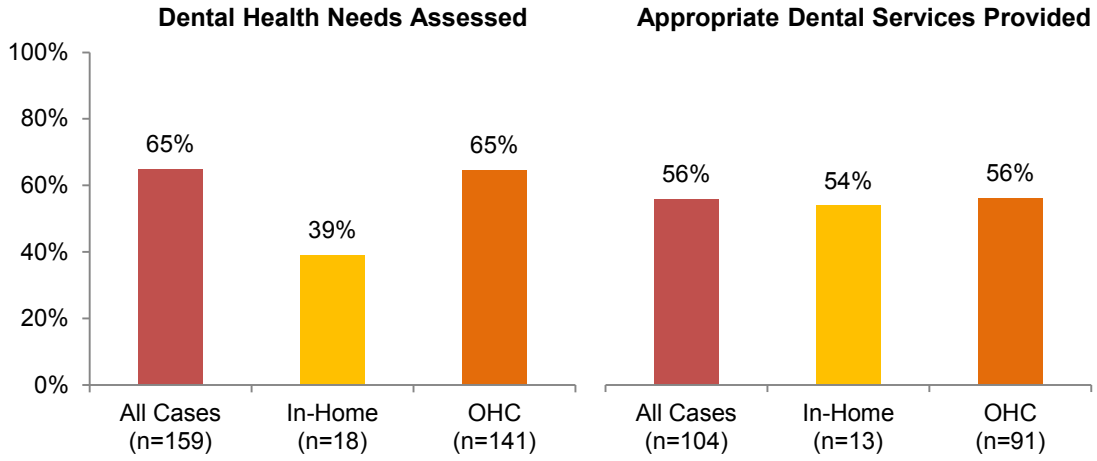


Figure 25. Assessment of Children's Dental Needs and Services Provided



For OHC cases only, Item 17 also covers agency monitoring of the use of prescription medications, and whether appropriate oversight was provided (such as ensuring that the child is regularly seen by a physician, following up with caregivers about administering medication, etc.). In 82% of applicable cases (40 out of 49), the local agency had documented evidence to support appropriate oversight of prescription medication use for physical health issues (results not shown).

Additionally, Item 17 seeks information to show that local agencies are meeting case management criteria required by federal statute, specifically involving children's health records and case planning. Table 12 shows those results for the 172 OHC cases reviewed.

Table 12: Federally Mandated Criteria for Out-of-Home Care Cases

	Total OHC Cases (n=172)
The child's health records are up to date and included in the case file	69% (119)
The case plan addresses the issue of health and dental care needs‡	51% (88)
Foster parents/care providers are provided with the child's health records	44% (75)
No evidence found	20% (34)

‡Note: this question encompasses any information pertaining to medical/dental needs in all permanency plans and case plans during the period under review.

Well-Being Outcome 3, Item 18

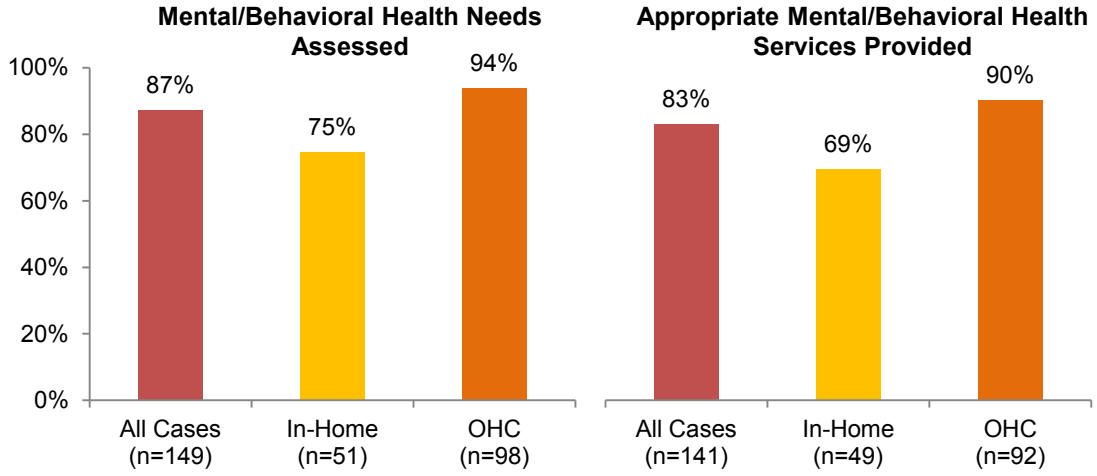
		Strength	Area Needing Improvement	No. Cases Assessed	*Federal Benchmark*
Item 18:	**Mental / Behavioral Health of the Child**	77%	24%	149	*90%*

Item 18 looks at addressing mental/behavioral health needs. As with Items 16 and 17, in-home cases are only applicable if these needs were the reason for agency involvement. A total of 149 cases were assessed for this Item.

Item 18 is rated as a *Strength* if there is documented evidence that accurate needs assessments were conducted and the agency made efforts to provide needed services (where applicable), as well as appropriate oversight of prescription drug use for children in out-of-home care (where applicable). As shown above, 77% of cases received a *Strength* for Item 18.

Figure 26 shows the results for this item. In 87% of applicable cases, an assessment of mental/behavioral health needs was documented. In 83% of cases, it was documented that appropriate services were provided to meet the needs identified.

Figure 26. Assessment of Children's Mental/Behavioral Health Needs and Services Provided



Item 18 also covers agency monitoring of the use of prescription medications in OHC cases. In 85% of applicable cases (34 out of 40), there was documented evidence that the local agency provided appropriate oversight of prescription medication use for mental and/or behavioral health issues (results not shown).

Next Steps

This report is the beginning of the continuous quality improvement process for Ongoing Services. It explains what is happening in case practice as defined by measures in the federal OSRI based on information found in the eWiSACWIS case files of the children and families sampled as part of this review. Future analyses will delve further into additional case reviews for more recent periods under review and will also examine specific items and outcomes in depth to increase understanding of Ongoing Services practice throughout the state. In addition, Wisconsin's Round 3 Child and Family Service Review will be held during the week of April 16, 2018. Wisconsin's child welfare system will be assessed and the state will be responsible for developing and implementing a federally-approved Program Improvement Plan (PIP). The findings from this report, along with the results of the CFSR and PIP, in conjunction with other key sources of CQI information, will steer specific efforts to improve child welfare services and outcomes for children and families in Wisconsin.

APPENDIX 1: CFSR Quick Reference Items List

Child and Family Services Reviews

OUTCOMES

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

Item 1: Were the agency's responses to all **accepted child maltreatment reports initiated**, and **face-to-face contact** with the child(ren) made, within time frames established by agency policies or state statutes?

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

Item 2: Did the agency make concerted efforts to provide services to the family to **prevent** children's **entry into foster care or re-entry** after reunification?

Item 3: Did the agency make concerted efforts to **assess and address the risk and safety** concerns relating to the child(ren) in their own homes or while in foster care?

Permanency Outcome 1: Children have permanency and stability in their living situations.

Item 4: Is the child in foster care in a **stable placement** and were any changes in the child's placement in the best interests of the child and consistent with achieving the child's permanency goal(s)?

Item 5: Did the agency establish **appropriate permanency goals** for the child in a **timely manner?**

Item 6: Did the agency make concerted efforts to **achieve reunification**, **guardianship**, **adoption**, **or other planned permanent living arrangement** for the child?

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.

Item 7: Did the agency make concerted efforts to ensure that **siblings in foster care are placed together** unless separation was necessary to meet the needs of one of the siblings?

Item 8: Did the agency make concerted efforts to ensure that **visitation between a child in foster care and his or her mother, father, and siblings** was of sufficient frequency and quality to promote continuity in the child's relationships with these close family members?

Item 9: Did the agency make concerted efforts to **preserve the child's connections** to his or her neighborhood, community, faith, extended family, Tribe, school, and friends?

Item 10: Did the agency make concerted efforts to **place the child with relatives** when appropriate?

Item 11: Did the agency make concerted efforts to promote, support, and/or maintain **positive relationships between the child in foster care and his or her mother and father** or other primary caregivers from whom the child had been removed through activities other than just arranging for visitation?

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.

Item 12: Did the agency make concerted efforts to **assess the needs** of and **provide services** to **children, parents, and foster parents** to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family?

Item 13: Did the agency make concerted efforts to involve the **parents and children** (if developmentally appropriate) **in the case planning** process on an ongoing basis?

Item 14: Were the **frequency and quality of visits between caseworkers and child(ren)** sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?

Item 15: Were the **frequency and quality of visits between caseworkers and the mothers and fathers** of the child(ren) sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?

Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.

Item 16: Did the agency make concerted efforts to assess **children's educational needs**, and appropriately address identified needs in case planning and case management activities?

Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

Item 17: Did the agency address the **physical health needs** of children, including dental health needs?

Item 18: Did the agency address the **mental/behavioral health needs** of children?

SYSTEMIC FACTORS

Statewide Information System

Item 19: How well is the **statewide information system** functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

Case Review System

Item 20: How well is the case review system functioning statewide to ensure that each child has a **written case plan** that is developed jointly with the child's parent(s) and includes the required provisions?

Item 21: How well is the case review system functioning statewide to ensure that a **periodic review** for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

Item 22: How well is the case review system functioning statewide to ensure that, for each child, a **permanency hearing** in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

Item 23: How well is the case review system functioning to ensure that the filing of **termination of parental rights (TPR)** proceedings occurs in accordance with required provisions?

Item 24: How well is the case review system functioning to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are **notified of, and have a right to be heard** in, any review or hearing held with respect to the child?

Quality Assurance System

Item 25: How well is the **quality assurance system** functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

Staff and Provider Training

Item 26: How well is the staff and provider training system functioning statewide to ensure that **initial training** is provided to all staff who deliver services pursuant to the Child and Family Services Plan (CFSP) that includes the basic skills and knowledge required for their positions?

Item 27: How well is the staff and provider training system functioning statewide to ensure that **ongoing training** is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Item 28: How well is the staff and provider training system functioning to ensure that **training** is occurring statewide for current or prospective **foster parents, adoptive parents, and staff** of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge needed to carry out their duties with regard to foster and adopted children?

Service Array and Resource Development

Item 29: How well is the service array and resource development system functioning to ensure that the following array of services is **accessible** in all political jurisdictions covered by the Child and Family Services Plan (CFSP)?

1. Services that assess the strengths and needs of children and families and determine other service needs;
2. Services that address the needs of families in addition to individual children in order to create a safe home environment;
3. Services that enable children to remain safely with their parents when reasonable; and
4. Services that help children in foster and adoptive placements achieve permanency.

Item 30: How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be **individualized** to meet the unique needs of children and families served by the agency?

Agency Responsiveness to the Community

Item 31: How well is the agency responsiveness to the community system functioning statewide to ensure that, in implementing the provisions of the Child and Family Services Plan (CFSP) and developing related Annual Progress and Services Reports (APSRs), the state engages in **ongoing consultation** with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

Item 32: How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the Child and Family Services Plan (CFSP) are **coordinated with services or benefits of other federal or federally assisted programs** serving the same population?

Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that **state standards** are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

Item 34: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for **criminal background clearances** as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

Item 35: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the **diligent recruitment** of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

Item 36: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of **cross-jurisdictional resources** to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

APPENDIX 2: Summary of the 2015-2016 Ongoing Services Case Review Findings

Performance Item or Outcome		Outcome Ratings			Item Ratings	
		Substantially Achieved	Partially Achieved	Not Achieved	Strength	Area Needing Improvement
Safety Outcome 1	**Children Are, First and Foremost, Protected From Abuse and Neglect.**	**76%** n=87	**--**	**24%** n=27		
Item 1	Timeliness of Initiating Investigations of Reports of Child Maltreatment				76% n=87	24% n=27
Safety Outcome 2	**Children Are Safely Maintained in Their Homes Whenever Possible and Appropriate.**	**64%** n=174	**18%** n=50	**17%** n=47		
Item 2	Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care				88% n=100	12% n=14
Item 3	Risk and Safety Assessment and Management				64% n=174	36% n=97
Permanency Outcome 1	**Children Have Permanency and Stability in Their Living Situations.**	**34%** n=59	**60%** n=103	**6%** n=10		
Item 4	Stability of Foster Care Placement				82% n=141	18% n=31
Item 5	Permanency Goal for Child				54% n=91	46% n=79
Item 6	Achieving Reunification, Guardianship, Adoption, or Other Planned Permanent Living Arrangement				66% n=114	34% n=58
Permanency Outcome 2	**The Continuity of Family Relationships and Connections Is Preserved for Children.**	**56%** n=96	**38%** n=65	**5%** n=9		
Item 7	Placement with Siblings				86% n=102	14% n=17
Item 8	Visiting with Parents and Siblings in Foster Care				57% n=90	43% n=67
Item 9	Preserving Connections				75% n=125	25% n=42
Item 10	Relative Placement				62% n=103	38% n=62
Item 11	Relationship of Child in Care with Parents				67% n=99	33% n=48
Well-Being Outcome 1	**Families Have Enhanced Capacity to Provide for Their Children's Needs.**	**46%** n=126	**39%** n=107	**14%** n=38		
Item 12	Needs and Services of Child, Parents, and Foster Parents				52% n=141	48% n=130
Sub-Item 12A	Needs Assessment and Services to Children				80% n=217	20% n=54
Sub-Item 12B	Needs Assessment and Services to Parents				59% n=149	42% n=106
Sub-Item 12C	Needs Assessment and Services to Foster Parents				85% n=138	15% n=24
Item 13	Child and Family Involvement in Case Planning				67% n=176	33% n=88
Item 14	Caseworker Visits with Child				69% n=186	31% n=85
Item 15	Caseworker Visits with Parents				48% n=121	52% n=129
Well-Being Outcome 2	**Children Receive Appropriate Services to Meet their Educational Needs.**	**87%** n=157	**2%** n=3	**11%** n=20		
Item 16	Educational Needs of the Child				88% n=158	12% n=23
Well-Being Outcome 3	**Children Receive Adequate Services to Meet Their Physical and Mental Health Needs.**	**59%** n=149	**16%** n=41	**25%** n=62		
Item 17	Physical Health of the Child				61% n=123	39% n=82
Item 18	Mental/Behavioral Health of the Child				77% n=114	24% n=35

APPENDIX 3: Ongoing Case Review Process

Case Reviewer Training

The Ongoing Services case record review was overseen by expert reviewers from the DCF Quality Review (QR) unit[37] who managed the review process, completed quality assurance activities, and reviewed cases. QR reviewers also coached other trained reviewers[38] who completed case reviews. Prerequisites to become certified as an Ongoing Services case reviewer included a minimum of three years of Ongoing Services experience or five years of child welfare experience. Reviewers that did not meet the minimum requirements needed to complete Pre-Service Training (Ongoing, Safety, Permanency Pre Service; 2.5 hours), Foundation Training (32 hours), and to have completed a Safety Booster training (8 hours) within the last two years.

In addition to prior child welfare case review experience (which all case reviewers had), reviewers completed the CFSR Online Training for the States before reviewing cases.[39] This federal training consists of four modules that require approximately 20 hours to complete. It provides background information on the CFSR, an introduction to the Onsite Review Instrument and instructions, and the opportunity to review a practice in-home and out-of-home case with immediate feedback. Following the completion of all four modules, there is an assessment that requires a score of 80% or higher to pass.

In addition to the federal CFSR Online Training for the States, DCF incorporated two additional components conducted by QR staff into the reviewer training curriculum. The first was an overview of how Wisconsin-specific Standards applied to questions in the OSRI and where to find information in electronic case records. The training took approximately 8 hours to complete and was conducted both in-person and remotely through the CQI SharePoint site for reviewers. The final part of the training was the completion of both a group training case and an individual test case using cases from Wisconsin. All reviewers were required to complete both cases and were provided feedback from QR staff. If, in the completion of the test case, a prospective reviewer's answers were not within a set margin of error, additional training cases and tests were assigned.

Review Procedures

Once reviewers passed training, they were randomly assigned cases to review and completed the case record reviews using only data in Wisconsin's Statewide Automated Child Welfare Information System (eWiSACWIS).They did not have access to any paper files nor did they conduct interviews with case workers, supervisors, the child, or family members. If, during the course of the review, a reviewer found a child to be unsafe, a referral was made to the Bureau of Safety and Well-Being (BSWB) to immediately follow up with the local agency.[40]

The OSRI was completed online through the federal CFSR Online Monitoring System (OMS), where review data was stored. Case practice on the cases selected for the random sample was examined for a set timeframe, or period under review (PUR). The PUR for the 2015-2016 Ongoing Services case record review assessed case practice between July 1, 2014 (PUR start date) up until the date that the case

[37] Core reviewers were from the Quality Review unit of the Quality Review and Performance Analysis (QRPA) section. QRPA is part of the Bureau of Performance Management (BPM), which is tasked with leading the CQI case record review process.

[38] Additional reviewers were trained from other units within DCF, including from the Bureau of Regional Operations (BRO) and the Division of Safety and Permanence (DSP), as well as staff from the Division of Milwaukee Child Protective Services (DMCPS) contracted agencies.

[39] See: https://training.cfsrportal.org/.

[40] This occurred on one occasion. BSWB contacted the county to follow up on the case in question.

review was started, or December 31, 2015 (PUR end date), whichever came first. The maximum PUR was 18 months.

Both in-home and out-of-home care (OHC) cases were reviewed. For the purposes of this review, an in-home case was defined as having no children from the family placed in out-of-home care during the period under review. An OHC case was defined as having a child placed in out-of-home care (in settings including a foster home, relative placement, group home, etc.) for at least 24 hours during the PUR. OHC cases reviewed focused on a single, target child selected at random, while in-home cases typically encompassed the entire family/all children residing in the home.

Data Analysis

Once reviewers completed reviews on all assigned cases, the review data was downloaded from the OMS in the form of Excel workbooks. Each Excel spreadsheet was prepared for data analysis, including removal of empty cells and conversion to one CSV file per CFSR Item. The CSV files were then uploaded to SAS version 9.4, where the data were further cleaned, merged, and analyzed. Duplicate cases were randomly deleted from the final sample for analysis. Additionally, the federal calculations were replicated using SAS to update the scores once duplicate cases were removed, in order to preserve original case review data in the OMS.

Quality Management

A detailed Quality Management (QM) plan was followed to ensure that information collected through the case record review was consistent across all reviewers and aligned with Standards. The QM plan was developed to help guide the case review process, clarify questions about the review instrument, reconcile inconsistencies that could affect case ratings, identify areas for further training and guidance, and track issues that needed discussion or resolution. There are two components to Quality Management:

- **Quality Assurance**, which comprises policies and procedures that are put in place to prevent potential errors prior to the case record review, and
- **Quality Control**, which involves established processes used to identify and rectify errors after the case record review is completed.

Training was a focal point of Quality Assurance. Apart from the initial training required to become a case reviewer, additional coaching and mentoring were provided as needed through SharePoint and the federal E-Training Platform. Check-in meetings and use of the discussion board were encouraged when reviewers had questions. QR team members were also available by phone for consult. Another element of QA was to avoid assigning cases to reviewers that could pose a conflict of interest, such as previous assignment to the case or personal relationship with any of the case participants.

Additional protocols were also followed in an effort to maintain Quality Control. For example, random cases were selected for re-review by QR staff in order to ensure that reviewers were maintaining rigor in adhering to the OSRI instructions. This included checking the eWiSACWIS case number, input of target children, and reviewing items that could be quickly verified without a comprehensive review of the entire record (e.g., Item 4 on placement stability is straightforward to verify).

Limitations

Despite in-depth training and a robust quality management plan, the results of the case record review may have limitations stemming from the review design and instrument used. It is important to keep these limitations in mind when interpreting results.

As noted above, reviews relied only on information recorded in eWiSACWIS. Examples of information that was limited or unavailable in the electronic case record included education information (such as an Individualized Education Plan [IEP] and/or school history), medical/dental information (sparsely completed medical/dental tab), and mental health information (psychological evaluations, Alcohol and Other Drug Abuse [AODA] assessments, psychiatric history, and medications).

Case selection created some limitations in that while there was a representative sample of 271 cases reviewed in total, each of the 18 items that make up the OSRI were not applicable for every case. As noted above, all in-home cases are excluded from assessment of permanency outcomes, which left only the 171 OHC cases applicable. Another example is Item 7 on placement with siblings, which is only applicable when the target child in out-of-home care had a sibling who was also in an OHC placement during the period under review. Additionally, there are other case-specific circumstances rendering a case not applicable for assessment of a certain item altogether, or excluded from a specific question. These criteria are described within the OSRI instructions and vary depending on the item, which can result in a different-sized sub-sample for questions pertaining to the same item. Such limited sample sizes prohibited more in-depth analysis.[41]

There were also limitations due to the defined period under review. The case selection criteria required the PUR to begin on 7/1/2014. When the review began in August 2015, the PUR was initially one year long (given that the PUR begin date was always 7/1/14 while the end date was the date the review of the case began). As the reviews continued, the PUR became longer over time and was eventually capped at 12/31/15 (approximately 18 months). A longer PUR can potentially affect the case review results in a number of ways. One example is Item 4 (Placement Stability). A child who is in OHC for a longer period of time is more likely to have more placement changes. A longer PUR also forces reviewers to look at cases that may have had periods of time with strong practice and, within the same case, areas where practice was weaker. Because the OSRI requires a yes or no response to each question, reviewers had to rely on professional judgment and use their discretion in determining which pieces of information would count in the final item or outcome score.

Finally, there are potential limitations stemming from changes in the OSRI instructions during the review period. The OSRI was finalized in July 2014, but states did not start using the Online Monitoring system regularly until 2015. Over the course of 2015, the Children's Bureau made several changes to OSRI that may have impacted results. While there is no comprehensive list of changes made, one example of a change is Item 7 (Placement with Siblings). Initially, it was determined that whenever a sibling group was separated, a justification was required or the item was rated as an *Area Needing Improvement*. The instructions on this item changed during the course of the review, and in cases where there were large sibling groups (4 or more) it was considered acceptable if smaller sibling groups were placed together (e.g., 2 in one home, 2 in another home).

[41] In particular, analysts intended to test hypotheses with review data (similar to what was done for the Access and Initial Assessment CQI case record reviews), but the sample sizes would have been too small to render meaningful results. (That is, there would not have been enough statistical power to detect statistically significant associations or differences should they exist.) Furthermore, the design of the OSRI often includes multiple constructs per question, which also severely limits the ability to infer causality between case practice and outcomes of interest.