

Florida's Child Welfare Regional Quality Assurance Model

Proposed Implementation Plan Effective March 11, 2008

Background

Upon his appointment, Secretary Butterworth acknowledged that child maltreatment tragedies continued to highlight performance gaps in Florida's Child Welfare program. To address the urgency for change, the Secretary directed the transfer of the Department's quality assurance staff from headquarters to the newly established regional offices effective July 1, 2007. This transfer allows for a comprehensive implementation of quality assurance activities across all circuits of the state. Paramount to this reorganization was the need to address the quality of service delivery at the local level.

Since that time, staff in the Office of Family Safety have worked closely with staff in the offices of the Assistant Secretaries for Programs and Operations, the Office of Strategic Planning and Innovation, Community Based Care (CBC) provider representatives, and regional staff to design a quality assurance system that focuses on clear assignment of organizational roles, responsibility, authority, and accountability at the regional and lead agency level as well as fulfilling state and federal expectations for child safety, permanency, and child and family well-being. In addition, the Department collaborated with the Youth Law Center and Eckerd Family Foundation, to ensure the Department's quality assurance model included specific quality assurance best practice standards.

There is no margin of error when we're working with children. No one is allowed a bad day. No one can let anything slip through the crack. For that slip is a child, and that crack is a life.

Secretary Bob Butterworth, 2007

Planning and implementation of the QA Implementation Plan is driven by Secretary Butterworth's [Six Guiding Principles: Integrity, Leadership, Transparency, Accountability, Community Partnerships and an Orientation to Action](#).

This plan implements a regional model for quality assurance¹ that focuses on service delivery and sets the framework for development of a comprehensive system that evaluates the quality of services, identifies strengths and needs of the service delivery system, provides relevant reports, and drives improvement in services and outcomes. The model includes:

- Requirement for immediate action to correct serious deficiencies.
- Development of uniform standards that focus on child welfare practice, and ensure quality assurance reviews assess critical standards that affect child safety, permanency and well-being, rather than focusing on discrete compliance requirements.
- Implementation of a child death review process that identifies areas of practice that need immediate attention.

¹ The detailed model is hereby incorporated by reference. The model and other reference material will be posted in the Family Safety section of the intranet document repository [<http://eww.dcf.state.fl.us/~fsp/newpages/repository/repository.shtml>], posted for reference on the Center for Advancement of Child Welfare Practice [<http://centerforchildwelfare.fmhi.usf.edu>], or may be requested through the Department of Children and Families, Office of Family Safety, PDFSQA, Tallahassee, FL 32399; 850-488-8762.

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- Development of a methodology for case samples that includes focus on children in specific age groups of concern, and provides for regional discretion in selecting special populations or topics for review.
- Acknowledgment of the critical role that Children's Legal Services plays in the case management process and integrates standards to assess lead agencies efforts to involve them as much as possible.
- Training for QA reviewers to ensure they have the analytical skills and training to conduct reviews consistently and with integrity across the state.
- Supervisory training by a national expert in child welfare that is mapped to the QA process.
- Plans for full implementation by July 1, 2008

The Department's Quality Assurance Model Addresses Accountability and Oversight to Ensure Protection of Florida's Children

The Preliminary Report from the Task Force on Child Protection states: "It is the culture of the Department of Children and Families and its partner agencies that is of critical importance and which must support a comprehensive and action-oriented approach to the needs of Florida's Children. This culture must be established by the leadership of each organization and must be manifested throughout each of the involved agencies at every point of leadership and with every involved member of staff. A culture that accepts and encourages only high expectations, high performance, high accountability, and maximum transparency is fundamental to the success of not only our organizations, but, through them, to Florida's entire Child Protection System." This plan incorporates recommendations from the Task Force on Child Protection and the Department's Inspector General's Report, #2007-0061, dated July 17, 2007.

Key Components

- 1. Accountability and Action.** Accountability is critical to ensure public trust in the child welfare system. Accountability is expected from regions, with responsibility for oversight of child protective investigations and of community-based care; from CBCs, with responsibility for non-investigative services; and from certain local sheriffs with statutory responsibility for protective investigations. The Quality Assurance System provides:
 - Designated staff at the regional and CBC level who will be accountable and responsible for full implementation of the Department's quality assurance process, and "fixing" identified gaps. Improvement follow-through is an expectation in all quality assurance activity.
 - Sheriffs with CPI responsibility will continue to conduct peer reviews per statute and submit quarterly reports to the Department.

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- Expectation for actions to be taken (contractual and otherwise) when a CBC fails to fully implement quality assurance requirements for services within their area of responsibility or fails to take immediate action when quality assurance performance issues are identified.
- Expectation for management action when Department employees fail to fully implement quality assurance requirements for protective investigation or other tasks within their area of responsibility, or fail to take immediate action when quality assurance performance issues are identified.

2. **Analysis of Findings and Reporting.** Service performance and data reporting is necessary to ensure trends are identified so that action can be taken by the Department and community based care agencies when needed. The model ensures data reporting is aligned with contracts, legislative measures, and new federal child welfare measures across the full range of activities of the child welfare program. This model requires reporting at the following intervals:

- Quarterly, uniform reporting and analysis by the CBCs to regions that targets specific QA activities.
- Quarterly, uniform reporting and analysis by the regions to headquarters that targets specific protective investigation activities.
- Annual reporting that includes a roll-up of the statewide performance of all CBCs and circuit child protective investigations, including incident reporting, child death reviews, and other sources of information such as sheriff peer reviews.

3. **Uniform Standards for Child Welfare.** Achieving excellence is only possible if all participants in the child welfare program are working toward a common goal with clear expectations. To support shared expectations, the QA model provides:

- Clearly defined standards and measures that everyone will be required to utilize. For example, most tools will be derived from a central database of validated, defined standards that can be used for various purposes.
- Uniform quality assurance review tools and reporting mechanisms.
- Review and analysis of performance data from automated systems.
- Consistent data collection formats in addition to automated systems so that we can analyze data and identify trends statewide.

4. **Regular or Periodic Reviews.**

Child Protective Investigation Reviews

- a) Hotline Reviews: The Florida Abuse Hotline contracts with a provider to conduct quality assurance monitoring of intake for reports alleging abuse and neglect, as well as of the

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function that conducts criminal background checks for field staff. An additional review component is in design where the Office of Family Safety and selected regional quality assurance staff in collaboration with Hotline staff will review a sample of reports taken by the Hotline to evaluate intake decisions and to evaluate subsequent actions by investigations.

- b) CPI Supervisory Reviews: Supervisors are required to review investigations 72 hours after an assessment has been made as to the child's safety; and every 30 days thereafter.

The QA Model prescribes an additional level of review intended for 100% of cases submitted for closure. This review captures critical quality of practice information not readily available from the information system, and provides an option for conducting the review as a face-to-face discussion between the CPI and the supervisor.

This is a new process and will include a standardized tool consistently applied throughout the state that offers qualitative assessment rather than a checklist of completed investigative activities. Due to concerns about this extra documentation possibly affecting performance measures in areas where CPI workload and/or turnover are excessive, the model proposes this initially as a pilot. [Note: an example of the proposed supervisory review tool for Child Protective Investigations, titled "Supervisory Review Tool draft Appendix I extract.doc", is provided with this transmittal. This example has been formatted to support the optional face-to-face approach; a file-review format will be developed and items included will be refined with field input.]

- c) Regional Discretionary CPI Reviews: Regional management will conduct circuit-level quality assurance on topics or focus areas selected at the region's discretion. Region will determine the characteristics to select cases for review; for example, by supervisor characteristics, by type of case, by timeframe, by geographic area, etc. This may include joint reviews by quality assurance staff and CPI supervisors. The minimum requirement is to conduct a review in each circuit at least once a year, defined according to local needs or performance gaps.
- d) Regional QA Review of CPI: Regional QA units conduct comprehensive reviews of CPI twice a year, taking a sample from each circuit that is valid and reliable on an annual basis.² These cases will be recently closed investigations regardless of disposition. Regional QA units will provide written reports of findings and roll-up data for analysis. There is currently no statewide automated roll-up mechanism in place. As in joint reviews, there is an existing tool that will be updated, with additional automation of detail and aggregate reporting. Other data, such as that captured in Florida's Safe Families Network and aggregated in the Department's Performance Dashboard, will also be analyzed to assess the status of regional CPI performance.

² The model includes a methodology that balances the need for broad CPI QA information during the year with the workload that it would take to do a large sample more than once a year. Thus, the requirement is to review a total sample at the "90/10" confidence level/interval aggregated for the year, but split the sample into two (or optionally more) segments.

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Community Based Care Reviews

- a) CBC Supervisory Reviews: This review requires case management supervisors to review 100% of the cases in their unit each quarter. The model provides a simple, straightforward guide that supervisors can use to think about the quality of casework, and systematically document their review for QA purposes. As with CPI Supervisory Reviews, this activity may optionally be conducted as a face-to-face discussion between supervisors and case managers (which is the approach some CBCs are already taking). The model includes a standardized tool and consistent, high-level aggregated reporting from each CBC to their region. [Note: an example of the proposed supervisory review tool for Child Welfare, titled “Supervisory Review draft tool Appendix J extract.doc”, is provided with this transmittal. This example has been formatted to support the optional face-to-face approach; a file-review format will be developed and items included will be refined with field input. During implementation, the workload associated with this QA documentation requirement will be assessed.]
- b) CBC Base Reviews: This review requires the CBC QA staff to review a sample of 25 case management cases each quarter, based on the approach used for the pilot CBCs by their external evaluator, Chapin Hall³. The database of standards will be the primary resource for these reviews, and will be the basis for drafting and validating the tool and interpretive guidelines. Other data, such as that captured in Florida's Safe Families Network and aggregated in the Department's Performance Dashboard, will also be analyzed to assess the status of CBC performance. [Note: an example of the proposed tool for CBC Base Reviews and Side-by-Side Reviews, titled “3bdrafttool-formattedblv2.pdf”, is provided with this transmittal, for your consideration. This tool will be refined with field input.]
- c) Collaborative Side-by-Side Reviews: This review requires the CBC QA staff team and regional staff (QA or program) to work in a peer review environment. The review is of a subsample of 8 cases from the 25 cases reviewed by the CBC each quarter. The approach calls for an objective monitor or facilitator (for example, region QA staff if region program staff are serving as peer reviewers) who guides and coordinates the review of each file, and provides objective reconciliation and arbitration among the reviewers as necessary. Again, this is based on the approach used by Chapin Hall. [Note: an example of the proposed tool for CBC Base Reviews and Side-by-Side Reviews, titled “3bdrafttool-formattedblv2.pdf”, is provided with this transmittal, for your consideration. This tool will be refined with field input.]
- d) Collaborative In-Depth Reviews: CBC QA and Regional QA conduct a more in-depth review of a subsample of the cases reviewed in the side-by-side process. This review will include gathering quality of practice information in ways not limited to looking at case files. For example, through case specific interviews (interviews with case manager, child, parent(s), providers and other stakeholders) or observation. These reviews will also include the collection of systemic factor information (information systems, training,

³ The Chapin Hall approach provides some innovative methodological concepts in its three major components (base, side-by-side, and in-depth quality reviews). Eight of the 25 cases are reviewed side-by-side. This approach has been well-received in the pilot sites.

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service capacity, etc.) that is not case-specific but that affects quality of practice. Although similar to the Florida CFSR in technique, and continuing to align with the federal outcomes, this review will include additional Florida-specific standards and a modified sampling approach.

Child Death Reviews

Child Death Reviews: This implementation plan will include development of a formalized child death review process. This process will be developed in collaboration with special counsel to the Secretary, staff in the Office of Family Safety, designated staff from lead agencies, and relevant law enforcement participants. Although there is a statutory requirement for a Statewide Child Abuse Death Review Team, the reviews follow closure of all law enforcement investigations and therefore do not support identification of opportunities for immediate action.

Other Reviews

- a) Executive Management Discretionary Reviews: The Secretary or other executive staff may determine a review of a particular process or topic is needed, or may require a statewide or localized special project be conducted throughout the year. This activity will likely require specially designed review tools and other protocols depending on subject matter. Discretionary reviews may also be assigned by regional directors for local purposes. These reviews will include high profile cases.
- b) External Federal Reviews and State Reviews: Various external entities (e.g., the federal Administration for Children and Families, and the Florida Office of Program Policy Analysis and Government Accountability) conduct audits and other reviews, and provide additional performance data and improvement opportunities on an ongoing basis. The January 2008 federal Child and Families Services Review will provide a comprehensive view of the state's system and result in the state being placed under a Program Improvement Plan (PIP). The PIP will be a significant focus of statewide quality assurance activity for the near future, generating more review and reporting requirements to avoid fiscal sanctions.
- c) Cross-Agency and Other Reviews: The Quality Assurance model specifies the use of multiple sources of information in addition to reviews conducted specifically for the Department's oversight of protective investigations and community-based care. For example, the collaborative review between the Department of Children and Families and the Department of Health relating to child protection teams, as specified in s. 39.303(6), F.S., will provide information about practice that will be analyzed in conjunction with other QA information. Another example is the use of data from foster care client exit interviews as per s. 65C-28.017, F.A.C.

5. Partnerships and Collaboration. Efforts for continuous improvement must take place at the community level. The QA model ensures partnerships and collaboration through:

- CBCs will update their Quality Assurance Plans to meet statewide criteria of the regional model. Regions will coordinate and provide technical assistance to assure plans meet

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local needs and address points of local flexibility. Regions will then review and approve the plan(s) for their CBC(s).

- Coordinated corrective action plans to ensure consistent follow through on performance gaps and issues.
- Flexibility for state and local needs by including provisions for quality assurance reviews at the discretion of the Secretary and/or regional directors.
- Local accountability for follow-up on significant service delivery gaps or deficits.

6. **Identification of Best Practice.** Continuous improvement is promoted through shared learning and the identification of best practice. This model provides an online repository with findings, best practice recommendations, and other qualitative information to push improvement throughout the child welfare system.

Changes to Quality Assurance: Past vs Present

	2007	2008
QA Staff	<ul style="list-style-type: none"> – Centralized Unit at Headquarters – CBCs have internal staff 	<ul style="list-style-type: none"> – Regionalized DCF staff – CBCs have internal staff
FL CFSR	<ul style="list-style-type: none"> – Six per year. – Rotating by zone to cover all CBCs 	<ul style="list-style-type: none"> – Incorporates federal CFSR standards into ongoing reviews
Methods	<ul style="list-style-type: none"> – Large sample sizes (based on a statistically valid sample which could be up to 300 files per quarter for a large CBC) – Inflexible, extensive checklists 	<ul style="list-style-type: none"> – Smaller, directed samples (25 files per quarter, based on age of child) – Tools focused on <u>core practice</u> and <u>quality of casework</u>, with some flexibility
Supervisors	<ul style="list-style-type: none"> – Supervisory operational reviews – Focus on compliance – Use of results not consistent or aligned with other QA 	<ul style="list-style-type: none"> – Supervisory operational reviews – Focus on quality of practice – Results incorporated systematically into ongoing QA
Flexibility	<ul style="list-style-type: none"> – Limited ability of regions to direct use of local QA resources 	<ul style="list-style-type: none"> – Regions have significant ability to direct local QA resources within statewide minimum requirements
QA Plans	<ul style="list-style-type: none"> – Static plans developed by CBCs with little to no regional involvement – High-level plan criteria 	<ul style="list-style-type: none"> – Dynamic plans by CBCs with region review and approval – Detailed statewide criteria

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	2007	2008
Improvement	<ul style="list-style-type: none"> – Multiple performance improvement and feedback processes, with isolated corrective action plans, limited follow through. 	<ul style="list-style-type: none"> – Aligned performance improvement processes, with coordinated corrective action planning and consistent follow through
Data And Reporting	<ul style="list-style-type: none"> – No standardization – Unconnected, limited-purpose databases – Disconnected analysis – Multiple reports 	<ul style="list-style-type: none"> – Standard data collection formats – Systematic analysis for trends and improvement – Integrated reports across multiple sources

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Implementation Activities and Timeline

Implementation activities will be overseen by the Assistant Secretary for Programs, with concurrence from the Assistant Secretary for Operations. Headquarters, regional, and CBC staffs will be identified in collaboration with the Assistant Secretary for Operations to form an Implementation and Oversight Team to assist in implementation of the regional QA model according to this implementation plan. Timeframes will be addressed and as deemed appropriate modified under the ongoing guidance of the Implementation and Oversight Team.

Implementation Tasks and Timeframes

	Phase 1 (Jan-Mar 08)	Phase 2 (Apr-June 08)
Updating CBC quality management plans. Update existing CBC quality assurance plans, develop the approval process, Regions approve plans.	Develop criteria and approval tool, Regions review and approve	Implement plans
Tool and Protocol Development: Modify, identify, or develop standardized review tools (CBC and PI), address scoring and scaling; collaborate with the independent oversight group (Chapin Hall) for pilot CBCs	Develop tools, protocols, methodology, interpretative guidelines and definitions, reporting mechanisms for basic reviews	Field test and automate; add special topic tools as necessary, continue standards bank development
Training Development Identify general training needs such as analytical skills or arising from the federal program improvement plan, and specific needs for new tools and activities.	Procure training design support; develop and implement training for basic reviews	Continue training development and implementation; expand to general analytical and other QA skills
Technology Support. Development of on-line content in the Center for the Advancement of Child Welfare Practice; develop processes to capture, store, communicate about QA products; provide support on integration of information sources; identify information systems capacity and other resources and collaborate with the Office of Information Systems.	Build core body of knowledge about QA processes, reports, data; develop business requirements and identify IS resources	Expand body of knowledge; automate tools, reporting, analysis

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	Phase 1 (Jan-Mar 08)	Phase 2 (Apr-June 08)
<p>Quality Improvement: Develop an improvement approach and processes for quality assurance planning and reporting, coordinate integration with the federal Performance Improvement Plan and other initiatives, address performance indicators and measurement topics.</p>	<p>Coordinate with Office of Strategic Planning and Innovation to design and develop basic state-level approach (team, reporting, analysis, etc.)</p>	<p>Integrate and automate reporting and corrective action tracking of performance improvement, especially in alignment with PIP.</p>
<p>Resource expectations. Ensure QA staff and other resources are balanced to achieve statewide minimum expectations in the regional model. Changes in situations that create undue burdens will be brought to the attention of the Assistant Secretary for Programs for adjustments.</p>	<p>Begin workload analysis for new activities</p>	<p>Continue workload analysis and prepare alternative recommendations or adjust as appropriate</p>
<p>Developing midyear and end of year reports. Developing a format for midyear and annual summary reports on CBC and regional statewide performance.</p> <p>CBCs will compile agency reports. Regions will be responsible for reviewing CBC reports and child protective investigation program data, submitting summary reports to the Office Family Safety. Office of Family Safety will compile for statewide perspective.</p>		<p>Annual report due: as soon as feasible after July 1, 2008 in alignment with performance measurement reporting.</p> <p>Address inclusion of additional sources of information, such as that from redesigned child death review process.</p>