Northeast Region
2014/2015
Quality Assurance Plan

Page 1 of 10
The Department’s Guidelines for Quality Assurance and Continuous Quality Improvement require each region and each Community Based Care (CBC) lead agency to submit an annual Quality Assurance Plan to outline the planned quality assurance and improvement activities for the coming year. At a minimum, the plan must describe the region’s quality assurance processes, data collection and analysis, internal reporting of review findings, and the region’s plan to improve practice.

The Northeast Region Quality Management Unit is under the Family Safety Program Office and is comprised of a regional Quality Manager, four Operations Review Specialists, and five Field Support Consultants. One of the specialist positions is devoted full time to coordinating child fatality reviews, data input, and report writing, the remaining three specialists are devoted full time to completing Child Protective Investigation (CPI) Rapid Safety Feedback reviews, and consultations, and the five Field Support Consultants are responsible for completing Rapid Safety Feedback Reviews and consultations, and devoting the remainder of their time coaching CPIs on active investigations involving a child age three and younger at high risk for serious injury or death.

The Northeast Region is comprised of 20 counties that are predominately rural in nature, and four judicial circuits including circuits 3, 4, 7 and 8. With the additional positions allocated following the 2014 Florida legislative session, the region now operates with two CPI Operations Managers, 8 CPI Program Administrators, 50 CPI Supervisors, 46 Senior CPIs, 245 CPIs (Plus 17 OPS CPIs), and a total of 51 CPI Units. Additionally, the region has 9 Field Support Consultants assigned to the two Operations Managers who will devote the majority of their time coaching CPIs on active investigations involving the most vulnerable children in terms of age and prior history, and on occasion conduct Rapid Safety Feedback reviews.

Chart 1 below provides the number of intakes received by the region and circuit each month for fiscal year 2013/2014.

**Chart 1**

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<tr>
<th>Entity</th>
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<td>Eighth Circuit</td>
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**Child Protective Investigation Staff Turnover**

A trained and stable workforce is critical to continuous quality improvement. Between July 1, 2013 and June 30, 2014, the region experienced 69 CPI separations for an attrition rate of 26%. The years of service ranged from one month to over 31 years, with the majority working less than three years. Performance was evaluated to be poor for 35% of the employees working less than one year, 40% for employees working less than two years, and 38% for employees working less than three years.
The region understands the importance of retaining experienced and competent staff. The regional director meets with all new hires to discuss the demands of the position as well as the training and support that will be provided to them. Each new hire is assured of having the time needed to train and prepare for the position, including 30 days of field shadowing, and adequate supervision and field support once assigned reports for investigation.

Communication and Collaboration with Community Based Care (CBC) Agencies:
Strong working relationships exist for both operations and Quality Management staff and the staff employed by the five Community Based Care (CBC) lead agencies operating in the NE Region. All of the Child Welfare Practice Model training was conducted jointly with region and CBC staff at all levels, and all region Child Welfare Practice Model implementation plans require the participation of management and supervisory staff from the CBCs, circuit and region staff. When CPI Rapid Safety Reviews identify shared safety concerns or case transfer or service related concerns information is shared and joint planning occurs to ensure the issues are resolved. CBC staff are also routinely invited to participate in consultations when information needs to be shared or action taken.

Stakeholder Involvement:
Department and CBC agency staff ensure data analysis, and information specific to performance goals are routinely shared with internal and external stakeholders through various forums such as the community alliances, CBC board meetings, and local and regional work groups. Regional implementation plans regarding the Child Welfare Practice Model routinely include representatives of the dependency court, Guardian ad Litem Program, Substance Abuse and Mental Health (SAMH), Domestic Violence Shelters, and critical contract and community service providers.

Planned QA/CQI Activities:
CPI Supervisor Reviews: CPI Supervisor reviews provide day to day oversight and guidance critical to ensuring thoughtful and timely decision making, and thorough investigations. Supervisory reviews provide opportunities to discuss planned and completed activities, identify gaps in information or information that needs to be reconciled or validated. Supervisory conferences provide a regular forum for gently challenging the conclusions drawn to encourage and support the development of critical thinking.

TACT Supervisory Reviews: The TACT supervisory case reviews are designed to assist the supervisor in increasing his or her level of comfort level with Florida's new practice model specific to cases handled through the Safety Methodology. The TACT trainer consultant reviews the investigation in advance of the scheduled conference call with the assigned supervisor to assist in reviewing the case. The focus is to work with each supervisor to facilitate a process to evaluate and analyze the CPI's documentation on assessment practices and how those practices are documented to support child safety decision making in alignment with the practice model. Toward the end of the phone call the assigned CPI, if available, is included in the phone consultation, but prior to this the TACT trainer consultant and supervisor reach agreement on the section of the case the supervisor wants to review and a "coaching strategy". The coaching results in a training effort by the CPI Supervisor with the CPI, and a practice effort on the part of the CPI supervisor to work with assigned staff on Safety Methodology constructs and case application. At the conclusion of the coaching session the CPI is excused and the CPI Supervisor and TACT trainer work together again for the purpose of providing feedback to supervisor on the coaching skills demonstrated. This process is similar to the original case review process in which the supervisor evaluates their own strengths and needs as a "coach" and then receives feedback from the TACT consultant about strengths and needs. The TACT training team also works with a regional liaison to coordinate "on site" visits to work with supervisors in larger groups. The focus of the group supervisor consultation reviews is to provide a forum to discuss specific issues related to Safety Methodology case practices that are "trending" and in need of further clarification. An example of some recent group work included attention to what and how to identify and document "Present Danger Assessments". At each group consultation the Methodology concept is reviewed and clarified for supervisors with the use of
many examples and practice efforts are initiated for purposes of application comprehension for supervisors. During most site visits there are at least two group sessions within the region with as many supervisors, QA staff and field support supervisors able to attend.

Region Rapid Safety Feedback Reviews: Three Quality Management Operations Review Specialists are devoted full time to conducting Rapid Safety Feedback Reviews. Additionally, five Field Support Consultants are involved weekly in completing two Rapid Safety Feedback Reviews. The region is responsible for conducting 100% of the Tier 1 and Tier 2 case reviews. The Tier 1 cases include active investigations open between 29 and 35 days, a caregiver between the ages of 13 and 26, and involving at least one child victim age 0 through 3 years: with allegations of family violence threatens child and substance misuse, and one of the following maltreatments: bone fracture, burns, internal injuries, or sexual abuse. Tier 2 cases include active investigations open for the same time frame, involving at least one child victim age 0 through 3 years of age; a caregiver, age 13 through 60, one prior investigation on a the identified child victim or other child victim in the home, or the alleged caregiver responsible; and allegations of family violence threatens child and substance misuse. If the goal of 60 reviews is not reached with the identified Tier 1 and Tier 2 cases, additional cases are identified using the criteria outlined in Tier 3 through Tier 6.

The Rapid Safety Feedback reviews are routinely completed by Quality Management Operations Review Specialists, and Field Support Consultants. Occasionally, trained Operations Managers, Family Safety Program Specialists, and Field Support Consultants assigned to operations assist with reviews. When a case consultation is warranted it is held with the involved CPI, CPI Supervisor, Program Administrator, and Operations Manager, when available, to discuss strengths, information gaps, information that needs to be reconciled or validated, and planned investigative activities. If the review identifies a child safety concern, the issue is documented in a Consultation for Recommended Action and is tracked to successful resolution.

Foster Home Licensing: All Child Placing Agencies (CPA) and Child Caring Agencies (CCA) are reviewed annually at a minimum. The on-site reviews are scheduled with the agencies at least 30 days prior to the re-licensure date. The licensing specialist uses an Excel tool to document each agency’s compliance with Florida Administrative Code 65C-15 for CPAs and 65C-14 for CCAs. Three tools may be used to document the review, depending on whether the agency is a runaway/emergency facility, maternity facility or a traditional group home. During the CPA review, personnel files, volunteer/intern files, and incident reports are reviewed. If the agency also provides private adoption services, a sample of adoption files are reviewed. If the agency licenses foster homes, a 10% sample of licensed homes is visited. During the foster home visits, critical safety criteria outlined in 65C-13 is reviewed. The administrative component consists of reviewing new or revised agency policies, and administrative documents such as the organizational chart, budget, and most recent financial audit.

When monitoring a CCA, personnel files, volunteer/intern files, incident reports, fire drills, menus, medication logs, activities schedules, and children’s files are reviewed. The on-site review also ensures cleanliness, appropriate furnishings, transportation, etc. The administrative component is the same as described above for CPAs. The expectation is the CCA will achieve 100% compliance. Any CCA that falls below an overall compliance of 90% is required to implement a formal corrective action plan. If the rating is above 90%, the agency is allowed to develop and implement an internal corrective action plan.

The on-site visit for CCAs and CPAs is summarized in a re-licensure report, and the report is input into FSFN under each provider's license page. Additionally, the regional licensing staff review CPA attestation packets for compliance with licensure requirements and participate in the weekly Foster Care Review Committee responsible for staffing the licensure or re-licensure of quality parenting concerns.
CBC Rapid Safety Feedback Reviews:
The CBC Quality Management staff are required to develop an annual Quality Management Plan for their respective agency that at a minimum commits to conducting ongoing targeted reviews of active cases to determine the quality of child welfare practice related to safety, permanency, and child and family well-being. Additionally, two Child and Family Service Reviews (CFSRs) are conducted each quarter, and require the reviewer to read case files of children served under the Title IV-B and IV-E plans and interview the participants in the cases.

Other Quality Management Activities: One of the four Operations Review Specialists is assigned full time to coordinate and review the child fatalities reported to the Hotline. The Child Fatality Prevention Specialist is responsible for facilitating the initial case staffing; conducting the final review of the completed investigation for closure; writing the Child Fatality Summary, entering and updating the data in the Child Abuse Death Reporting (CADR) information system, providing county and region data related to the cause and manner of child fatalities; and providing training as needed on conducting child fatality investigations and the region’s review process.

Quality Management staff are asked to conduct case reviews when there are concerns about case handling. Additionally, Quality Management staff participate on practice related work groups throughout the region.

Rapid Safety Feedback Review Findings: Rapid Safety Feedback Reviews are conducted weekly, with the focus on child safety. The electronic record is reviewed against the five review items, using the statewide review guidelines. Review item 1 is applied to all investigations, and is critical to assessment and decision making. The CPI is required to access the criminal history and prior abuse and neglect history, explore if there are frequent visitors in the home with unsupervised access to the children, and whether the family ever resided in another state. This review item is often negatively impacted when the CPI does not identify all of the prior abuse and neglect history or does not request checks on all subjects of the report and household members. An opportunity for improvement remains in accurately analyzing the prior history and assessing the impact on child safety.

See Chart 2 below for region performance on Item 1: Child Abuse and Neglect Reports, Prior Services and Criminal History.

Chart 2

Item 2 addresses the sufficiency of the interviews and observations documented, relevancy of collateral contacts, and the efforts made to validate and reconcile information critical to assessment and decision making. The reviews document improvement in information collection that goes beyond the historical maltreatment focused investigation. Information is gathered around the six domains, and additional
attention is being given to child development and functioning, and observations of the parent and child interactions.

Opportunities for improvement remain in ensuring relevant observations are documented for each child regarding their development and interactions. Additionally, thought needs to be given to collateral contacts because of the potential importance they may play in accurately assessing the caregiver’s protective capacities over time. Opportunities also remain in ensuring information critical to assessment and decision making is reconciled and validated when needed.

See Chart 3 below for region performance on Item 2: Information Collection.

Chart 3

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<thead>
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<th>Month</th>
<th>NE Region</th>
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<tr>
<td>Jan-Feb 2014</td>
<td>35%</td>
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<tr>
<td>March 2014</td>
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<tr>
<td>June 2014</td>
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**Item 3** is applied to all investigations. The reviewer must consider if the family's behavior, conditions or circumstances that resulted in harm to a child were accurately identified, based on understanding how the family functions outside of the incident under investigation. The danger threat may occur as a present danger (immediate, significant, and clearly observable) or an impending danger (a persistent and ongoing out-of-control condition in the home). Historically, a parent’s protective capacity was assessed within the context of the active investigation based on the caregiver’s level of cooperation, and willingness to take appropriate action. Determining the accuracy of the CPI’s assessment of a caregiver’s protective capacities requires the reviewer to determine if the CPI and CPI Supervisor considered both the caregiver’s current demonstration of taking protective action on the child’s behalf, as well as the historical record of taking such action. This area represents one of the more challenging in the child welfare practice model, because the accuracy of the assessment is dependent upon focused interviewing and thoughtful decision making about collateral contacts that can inform the assessment of protective capacities.

**Item 4** is applied to investigations when present and/or impending danger is identified. The reviewer must consider if there is evidence of collaborative decision making in developing the plan, if the plan is sufficient to manage and control the danger while information collection continues, if the safety services identified are appropriate, referred and engaged, and if there is sufficient CPI oversight of the plan.

Improvement was noted in safety planning during this six month period, with the accurate identification of danger threats, and appropriate identification of formal and informal safety services. Opportunities for improvement remain in ensuring each plan clearly documents the CPI’s ongoing responsibility for monitoring the plan.

See Chart 5 for region performance regarding **Item 4: Safety Planning**.

**Item 5** requires the reviewer to consider whether the initial (not pre-commencement) supervisory consultation documents a collaborative discussion with the CPI; if ongoing supervisory consultation is sufficient to provide the guidance and direction needed; and if critical issues identified by the supervisor are timely resolved by the CPI.

The reviewers have noted ongoing consultations are documented in the records reviewed, but the documentation does not consistently capture all of the consultations or the CPI’s contribution to the discussions. Additional guidance is being provided during the RSF consultations conducted by the
Quality Management specialist and field consultants. The reviewers have also noted delays in the CPI Supervisor following up on critical activities in these high risk investigations that could negatively impact the CPI's assessment or decision making. Additionally, some delays have been noted when investigations are commenced in one county in the region and subsequently transferred to another county in the region.

See Chart 6 for region performance regarding Item 5: CPI Supervisor consultation, support and guidance.

Chart 6

![Supervisory Consultations Chart](chart6)

Additional attention should be given to the timely completion of all required background checks, and ensuring the prior abuse and neglect history is accurately identified for all subjects of the report and household members, and the impact on child safety analyzed.

See Chart 7 below for each Program Administrator's overall performance by review item for January through June of 2014.

Chart 7

<table>
<thead>
<tr>
<th>Program Administrator</th>
<th>Background Checks</th>
<th>Information Collection</th>
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<th>Safety Planning</th>
<th>Supervisory Consultations</th>
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Continuous Quality Improvement Activities:

**Central Hire:** The NE Region established a central hiring position that will report directly to the Family and Community Services Director. The position will focus on effective strategies for improving
recruitment, selection and retention of CPIs, with the goal of driving improved outcomes for the children and families served.

**RSF Data:** The quality assurance review findings are used to coach CPIs and CPI Supervisors on opportunities for improvement, and identify ongoing and refresher training needs.

**Quality Management and Operations Field Support Consultants (FSCs) and Operations Review Specialists (ORSs):** A monthly forum is provided to the region’s 14 FSCs to provide an avenue for information sharing, skill enhancement and formalized training. The FSCs, and ORSs are tasked with focusing coaching on pre-commencement as it relates to identifying all criminal and prior abuse and neglect history for all subjects of the report and household members; analyzing the information for its impact on child safety and related decision making; ensuring sufficient information collection to complete the Family Functioning Assessment – Investigations; and an accurate assessment of the caregiver’s protective capacities over time.

FSCs and ORSs in Quality Management will conduct weekly Rapid Safety Feedback reviews on open investigations with elevated risk for serious injury or death. Additionally, the FSCs assigned to both Quality Management and Operations will be tasked with observing one supervisory consultation per month by each CPI Supervisor in their assigned area, and providing feedback on the strengths and opportunities for improvement.

The region has developed a training plan for the staff involved with continuous quality improvement efforts, including Quality Management ORSs and FSCs, and Family Safety Specialists. The plan will include some of the following opportunities for training and participation:

- Office of Child Welfare Statewide Training
- Super Safety Practice Expert (SPE) sessions
- ACTION Train the Trainer Sessions
- TACT Training
- Facilitating Case Fidelity Reviews and Learning Circles
- Coaching on Time Management and Organizational Skills
- NE Region Front Line Guide Book Training
- Leadership Opportunities Training
- Substance Abuse, Domestic Violence, and Mental Health Issues and Interventions Training
- Local Integration Planning Groups Comprised of CPI, CBC, and SAMH staff.

**Focused Work Groups:** The region has established a Barrier Buster work group in all areas of the region focused on timely communication and coordination regarding the full implementation of the Child Welfare Practice Model; reviewing data and developing improvement strategies specific to the 0 through 3 population, as well as other areas in need of improvement; developing a shared training plan; reviewing critical processes and establishing protocols when needed; and developing working agreements when warranted.

**Attachment I** is an organizational chart that provides a visual of the regional and circuit positions and resources available to drive and support the region’s continuous quality improvement efforts.
Region leadership understands quality occurs when hiring decisions are appropriate; training, both initially and ongoing is sufficient; mentoring and coaching is an integral part of practice in the office and field; and opportunities for integration and collaboration with Quality Management, Operations, and CBCs are maximized. Efforts are ongoing to share review findings among Quality Management, Operations, Field Support Consultants, Specialists, and CBCs to inform training needs and provide the ongoing field support needed.