Hillsborough Kids Inc.
Fourth Quarter QA Side by Side Review
Exit Conference 5/14/10

Outcomes:

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<th>4th Quarter FY 08/09</th>
<th>2nd Quarter FY 09/10</th>
<th>3rd Quarter FY 09/10</th>
<th>4th Quarter FY 09/10</th>
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</thead>
<tbody>
<tr>
<td>Safety</td>
<td>48%</td>
<td>54%</td>
<td>66%</td>
<td>75%</td>
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<tr>
<td>Permanency</td>
<td>59%</td>
<td>63%</td>
<td>72%</td>
<td>64%</td>
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<tr>
<td>Well-Being</td>
<td>67%</td>
<td>56%</td>
<td>75%</td>
<td>68%</td>
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<tr>
<td>Overall</td>
<td>60%</td>
<td>56%</td>
<td>72%</td>
<td>67%</td>
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The fourth quarter Hillsborough Kids Side by Side Quality Assurance Review was held April 19 and 20; a de-briefing with case managers, supervisors and program directors took place April 21 and the exit conference was held on May 14, 2010 with representatives from the lead agency, case management agencies and DCF administration and contracts. The review period for the fourth quarter was July 1, 2009 through March 31, 2010.

Four of the eight cases in the sample were In-Home services cases (3 from Devereux and 1 from Gulf Coast) and the remaining four were Out of Home cases (2 from Children’s Home Society, 1 from Camelot and 1 from Devereux). The ages of the children ranged from 2 – 4 years for the in-home cases with court ordered supervision due to substance abuse and domestic violence. Children receiving Out of Home care were ages 11, 12, 14 and 16 years and all are in the custody of a relative. The two younger youth have a goal of reunification and the teens goals are permanent guardianship. The 11 and 12 year old were removed due to substance abuse, inadequate supervision and family violence and were in Out of Home care for twelve and thirteen months respectively. Both teens have been in out of home care for three and six years respectively and were initially removed due to physical abuse.

Hillsborough Kids performance fluctuated over the past few quarters but has shown overall improvement in safety, permanency and child well-being since the fourth quarter of FY 08/09.

Positive Steps

- There was no re-abuse or re-neglect of the focus child during the period under review.
  During the last two quarters there has been no re-abuse or re-neglect for both in-home and out of home cases indicating that case management has identified child safety as a critical factor warranting ongoing assessment. During this review, an abuse report was received resulting in some indicator findings for substance abuse at the birth of a child into an active, in-home services case;
however concerted efforts were made to provide or arrange for appropriate services for the family to protect the child and prevent the child’s entry into out of home care.

- **Completed service referrals were consistent with the needs identified through investigative assessment and other assessments related to safety.**
  
  Reviewers located a myriad of referrals from a variety of providers including: positive parenting, FRS, FIS, FSPS, DACCO Zero Exposure Program, Interventions and FRANC to ensure placement stabilization and provide parenting supports and interventions.

- **Concerted efforts were made to identify, locate and evaluate other potential relatives and possible permanent placements for the child.**
  
  This was apparent in several cases where documented efforts by case managers resulted in relative placements. Considering the two teens were ultimately placed with relatives after having been in foster care for years; this achievement was due to diligent and persistent efforts by the case managers to obtain permanency for these youth.

- **In three of the four applicable cases, the child experienced no more than two out of home care placement settings during the period under review; and for the child who experienced more changes, all placement settings were planned in an effort to achieve the case plan goal or to meet his needs.**
  
  As mentioned earlier the 16 year old youth would not have experienced the change in placements had it not been for the relative’s unexpected decision to no longer be considered for placement. Exit interviews were conducted to discuss the previous placement experience and there were no documented concerns.

- **When sibling separation occurred, in two instances, there was clear evidence that it was necessary to meet the child’s needs.**
  
  In one instance the focus child’s younger sibling was in foster care and the relative was unable to care for him due to health reasons, but plans are in the works to place the siblings together in the near future. In the other case, the sibling in foster care was committed to a permanent guardianship with a non-relative and while the focus child was waiting to be placed with a relative he was briefly placed with his sibling.

- **Concerted efforts were made to ensure visitation was sufficient between the child and the parent to maintain or promote the continuity of the relationship between them.**
  
  This standard was rated at 100% for the three applicable cases.

- **In all out of home care cases, reviewers found concerted efforts to maintain the child’s important connections.**
Evidence was found in improved efforts to obtain ICWA verification (63%) and contacts with extended family. One case manager transported a youth to school for continuity and later provided him with bus passes.

- **Ongoing assessment of needs was conducted to provide information for case planning purposes:** Child 86%, mother 83%, father 80% and caregivers 75%.
  This is a continued strength from the prior review as documented in the case notes and Judicial Review Social Study Reports. Parents were invited to staffings and efforts to support and encourage their engagement with services was evident. The support of father’s engagement increased from 33 to 75% from the prior review.

- **Concerted efforts were made to actively involve all case participants in the case plan process in 7 of the 8 cases.**
  Evidence of participant involvement is included in the family assessment summary and during home visit documentation in case notes. This continues to be a strength at 88% overall and 100% as to the fathers.

- **The child’s educational and mental/behavioral health needs were assessed in all applicable cases and when educational needs were identified in two cases, services were engaged. When needs were identified to address mental/behavioral health issues in 3 cases; services were provided and the agency followed up on all treatment plans that were ordered.**
  There was evidence of report cards in the file and discussion with school personnel regarding performance as well as behavior issues. One of the teens was assessed after not having attended school for two years and was advanced two grade levels. Another teen was assessed for substance abuse and sexual abuse and was provided therapeutic intervention.

- **One teen was prescribed psychotropic medication for ADHD and a court order was obtained and FSFN documentation is current.**

- **In all but one case, Judicial Reviews were held timely and the reports provided all pertinent details relating to the child.**
  This was a strength noted during the 3rd quarter review as well.

**Opportunities for Improvement**

- **The frequency and quality of contacts.**
  This area declined during this quarter’s review (from 50 to 25%) in large part because of the lack of **unannounced visits with the child.** Reviewers could not always locate face to face sheets in the electronic file to determine if unannounced visits occurred every three months. Documentation in FSFN does not clarify if contacts were unannounced or not. In a majority of the cases the child and caregiver was seen every 30 days, however there were situations when...
the risk level was high and the frequency of visits were not sufficient to ensure child safety. The quality of the visits increased from 38 to 50% this quarter there is still much room for improvement. It was not always noted that the case manager spoke to the child alone during visits. Contacts with young children did not always document any efforts to engage the child in conversation, however minimal considering age, or if observations to confirm sleeping arrangements were adequate to meet the child's needs. Also, discussion with the parents as to what was learned through positive parenting was documented as “learning a lot”. In another case, documentation did not address the specifics regarding the father’s visits with the child or in another case with the mother related to the care of the children; if and when she is incarcerated, nor was there documentation of case manager’s engagement of mother in discussion related to identifying the focus child’s father.

- **The frequency and quality of family assessment.**
  Although six month family assessments have been completed in FSFN, continued efforts are needed to ensure that they adequately reflect an assessment of immediate and emerging safety concerns pertaining to the family. Additionally, it is critical that they are updated at least every six months and at critical junctures in the case, such as when new reports of abuse and/or neglect are received or when there are changes in family factors. Reviewers found one of the three initial family assessments was completed timely and was qualitative. Some assessments were not approved until several months later. One 6 month assessment was actually initiated in 3/09 but was not approved until 12/09. Despite that delay, credit was given because the information was current and an accurate assessment of the family situation. Four of the seven six month assessments were rated as timely and qualitative. Standards will be enforced next review so that the assessments will need to be both timely and qualitative for a positive response.

- **Enhanced supervisory oversight and follow up.**
  Supervision was occurring more frequently then quarterly; however (50%) four cases were not rated as having a qualitative supervisory review. Reviewers noted that the supervisor was not considering all aspects of the child’s safety, such as when the risk level did not coincide with the frequency of visits, and for well-being when identified dental and physical health needs went unaddressed, and permanency when TPR petitions were not filed and case plans were expired. Reviewers found evidence of safety plans but they were not signed and there was no evidence that they had been developed and/or discussed with the family. There were two instances where reviewers did not find evidence that a thorough home study was completed prior to placement in an unlicensed home.

- **Evidence of current case plans.**
  Only one of the eight cases reviewed contained a current case plan. Most of the reviewers reported expired case plans with one dating back to 10/09 and four
dating back to 12/09. This is an area in need of attention from the DCF and HKI administration, the Office of the Attorney General and judiciary. Often it was noted that the court extended case plans or refused case plans that were submitted and worked off of expired case plans. There did not appear to be any urgency to address this issue which has been a trend over several review periods.

- **Support parents in making decisions about their child.**
  This standard was rated 0% for both mothers and fathers in all applicable cases. This standard, if met, could enhance permanency for children. Since we have made strides in assessing the needs of the parents and child additional focus on this standard may help to encourage parent engagement with services as well as enhance the parent/child relationship through participation in extra curricular activities, school functions and every day activities such as hair cuts, home-work assignments and playing catch, riding bikes and joining sports.

- **Filing timely TPR petitions and documenting the compelling reason and exception for not filing.**
  Three of the four applicable cases included children who were in out of home care for at least 12 of the most recent 22 months; however a TPR petition had not been filed. One of the three cases did include documentation of a compelling reason for not filing a petition.

- **Practice quality documentation.**
  Overall case documentation continues to need improvement, and help paint a picture to the reviewer of what the case manager is seeing during contact with providers, parents, caregivers, and the child. Documentation should answer the questions of who, what, when, where, why and how.

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**Initiatives in Progress**

Due to the brief period of time between the third and fourth quarter side by side reviews, it is recommended that the agency continue implementation of these initiatives which were recommended last quarter. Additional time is needed to determine the impact on the quality of service provision.
• Continue efforts to track the timely completion of qualitative initial family assessment upon meeting the family in order to make a determination of immediate and long term strengths and needs. Ensure that ongoing assessments continue throughout the life of the case, utilizing information obtained from case participants, service providers, observations and interaction, as well as, information learned from other sources to provide a complete and accurate assessment of current family functioning as long as the case remains open to services.

• Documentation remains an area for quality improvement. The degree of documentation may differ slightly depending on the elements of the case and the age of the child, but physical appearance, developmental progress, behavioral indicators, emotional state of the child and interactions with caregivers should provide a sense of each child’s state of overall well-being. Phrases such as “free of marks and bruises” or “child appeared happy, healthy and bonded” are not sufficient when assessing qualitative interaction and observations.

• In order to support information provided by parents, caregivers, youths, and providers, verbal communication, documentation, progress reports and/or records should be obtained to verify the information is actual.

• Be creative in supervisory functions.
• Develop a strategy for enhanced oversight of case management supervisors by the case management organizations which will include mentoring and modeling opportunities.
• Read FSFN chronological notes to determine current case activity.
• Challenge case managers to use critical thinking.
• Supervisors should periodically accompany case managers on field visits and use the opportunity to discuss case specifics and identify issues.