The HKI exit conference was held on March 26, 2010 and the review period spanned nine months from April 1, 2009 through December 31, 2009. The sample was comprised of six out of home cases, one in home case and one case which was both in home and out of home during the review period. Three cases had the goal of adoption. Two cases had the goal of maintain and strengthen, and the remaining three cases had goals of APPLA, reunification, and permanent guardianship. The number of months the case had been opened as of the end of the review period ranged from seven (7) to fifty-seven (57) months. One of the cases had been previously open for services, closed and then reopened one month after reunification because the child and mother were arrested together. A second case was a reactivation because the adoptive mother decided to relinquish her parental rights after an abuse investigation was called in on the family.

Positive Steps

- **There was no report of re-abuse, re-neglect received during the period under review.**
  During the last two quarters there has been no re-abuse or re-neglect, indicating that case management has identified child safety as a critical factor warranting ongoing assessment.

- **Children’s current placements were stable and appropriate to meet the child’s needs with no apparent or significant risks or projections for disruption.**
  Of the seven applicable cases in the sample, only one child experienced more than two placement changes during the review period. The reason for the placement changes were a result of the youth’s behaviors. Therapeutic services were placed in the most recent home to assist with stabilizing the placement.
• There were current case plans in seven of the eight files, and all of the plans had appropriate permanency goals.
  In seven of the eight cases the case file contained a current (not expired) case plan with the appropriate goal identified. In one case the case plan was not located and there was no evidence an updated case plan had been filed.

• When sibling groups were not placed together there was clear evidence separation was necessary to meet the children’s needs. Sibling contact was maintained and encouraged when not placed together.
  In four of the five applicable cases the siblings were not placed together; however there was evidence the separation was necessary to meet their needs. When siblings could not be placed together, there were concerted efforts to ensure sibling visitation was occurring on a consistent basis.

• Supervision was occurring frequently and there was evidence that later in the review period the modeling and mentoring guide was being utilized.
  In all cases reviewed supervision was completed at least quarterly, and for the majority of the cases on a monthly basis. Reviewers noted that later in the review period it was evident the modeling and mentoring guide was being used and appropriate recommendations were made more consistently.

• Judicial Review Social Study Reports were timely and thorough.
  In seven of eight cases reviewed the JRSSRs were being completed timely, and information contained in the reports provided the courts with thorough updates.

• Documentation of ongoing verbal communication with service providers regarding the effectiveness of services for case participants.
  In a majority of the cases it was noted that there was ongoing verbal communication between the case manager and service provider regarding the effectiveness of services. One case involved the child being involved with the Juvenile Justice system, and there was excellent documentation to support the communication between the case manager and juvenile probation officer.

• Independent Living Services to children 15 to 18 years of age.
  There were two children who met the age criteria for IL Services; however only one was eligible to receive services, as one child was living with a non-relative. Documentation supports the child was receiving the appropriate IL services, as the child was involved in all aspects of the case. She was involved in the development of her educational plan, and involved in IL staffing and transitional living staffing during the review period. She also attended the court hearings. Documentation supported good communication between the case manager and IL coordinator.
• **Staffings were taking place regularly.**
  Reviewers noted an increase in appropriate staffings that occurred during the review period; they included permanency staffings and multi disciplinary staffings at critical junctures. Reviewers also noted that information being presented and recommendations made at the staffings were appropriate. Two cases were applicable for a multi-disciplinary staffing when placement planning was needed prior to the move to discuss the placement or what the plan was for the child if the move could not be avoided. In one case the 17 year old child was residing in a group home, but was moved to another home that better suited her independent living needs. This was a planned move and the child was involved in the decision making process prior to the move occurring. In another situation, the child had severe behavioral issues that led to his placement changes. Prior to the change in placements an MDT staffing occurred, in addition disruption staffings were held prior to the child’s change in placement.

• **Concerted efforts were made to assess physical and dental health needs.**
  Reviewers noted that documentation supported an increase in physical and dental health needs being addressed during visitation with the caregivers and children when age appropriate.

• **Use of FSFN Family Assessments.**
  A family assessment was located in FSFN on all cases reviewed. In four out the eight cases reviewed the assessment was rated as being qualitative, with two of the cases having two assessments completed during the period under review. It is evident that the agencies have made concerted efforts to use the FSFN automated assessment during the review period.

• **ICWA was located in four of the eight cases reviewed.**
  ICWA has been a continual need, but an increase in completed forms was seen during this review.

**Opportunities for Improvement**

• **Quality of contacts.**
  Documentation lacked observations and interactions of the child, and that the child was being seen alone. Also, concerted efforts to engage case participants in the case planning process with both the child and parents were not thoroughly documented.

• **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.
• **Increased supervisory oversight.**
  Supervision was occurring more frequently than quarterly; however the majority of 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, well-being and permanency; and there was no evidence that follow through was completed on supervisory guidance or the reason it was no longer necessary. Directives provided by the supervisor were generic or instructed the case manager to complete daily job functions, and did not provided specific directives and timelines. In one case the paternal grandparents where not supportive of the mother, telling the child to say she felt uncomfortable around the mother; however there was no documentation that directives were provided for the case manager to address the matter in a timely manner. In another case, the review stated the parents were having weekly urine analysis testing; however it did not specify the results of those tests.

• **Lack of visitation and safety plans located.**
  One of three applicable cases included a visitation plan for the parents located in the FSFN record or case file. Reviewers noted that when a safety plan was necessary, documentation did not support that it was completed.

• **Medical and dental records were not obtained**
  Though there was an increase in the documentation in the FSFN record that medical and dental needs were being addressed; reviewers noted the lack of verification from providers to support the information was accurate.

• **Unannounced visits with the child.**
  In seven of the eight cases reviewed the child was seen every 30 days; however documentation did not support that one in three visits with the child was unannounced by the case manager. Visits can occur at the child’s residence or other location that is critical to the life of the child (day care, school or therapeutic setting).

• **Follow up on referrals provided.**
  There was a lack of documentation to support that case managers were following up on referrals to ensure participation with services.

• **Lack of 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.
Initiatives to be Considered

1. 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.

2. 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.

3. 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.

4. 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.