Safe Children Coalition

Sarasota Family YMCA, Inc.
Safe Children Coalition

Quality Assurance Review Findings
and Performance Outcomes Results

FY 2014 – 2015 Annual Report
Quality Management Team

The Sarasota Y/Safe Children Coalition Quality Management Team is comprised of staff members who bring professional experiences from a variety of different backgrounds. The Quality Management Team is under the supervision of the Performance and Quality Improvement Manager. The Quality Management Team consists of (3) Quality Management Specialists, (1) Quality Management Client Relations Specialist and (1) Quality Management Paraprofessional.

Each member of the team performs various duties and provides oversight for special areas within the System of Care. Some of these include but are not limited to:

- Evaluating and Assessing the Quality of Services provided to children and their families by case management agency partners, through the review of case records
- Monthly Continuous Quality Improvement (CQI) Meetings
- Monitoring of Psychotropic Medications
- Monitoring Missing Children and Human Trafficking compliance
- Managing and Oversight of Critical Incident Reporting
- Reviewing Licensing Files and facilitating Licensing QA Staffing
- Monitoring Child Exit Surveys, Customer Service Surveys and Foster Care Surveys
- Monthly Performance Reports
- Recording and Responding to Client Relations Issues
- CIRRT Reviews (when needed)
- Other case file reviews

Quality Management Activities 2014-2015

The Sarasota Y/Safe Children Coalition Quality Management Team evaluates the quality of services provided to children and their families using various standardized tools to assess a child’s safety, permanency and well being. The Sarasota Y/Safe Children Coalition completed four-hundred and sixty-five (465) case file reviews during the course of the FY 2014-2015.

The Sarasota Y/Safe Children Coalition completed one-hundred (100) Rapid Safety Feedback reviews; fifty (50) Well-being Reviews; fifty (50) Permanency Reviews; forty (40) Psychotropic Medication Reviews; twenty-five (25) Licensing Reviews; eight (8) CFSR and one-hundred and ninety-two (192) Supervisory Reviews.

Case file reviews are based on a sampling of children who are or who were in out-of-home care and children who are or who were served in their own homes. Samples are large enough to make statistical inferences about the populations served. The Sarasota Y/Safe Children Coalition follows and complies with the Department of Children and Families quality assurance guidelines – “Windows into Practice”- which includes the framework for conducting quality assurance reviews.
Quality Management Summary and Analysis

Safety: Rapid Safety Feedback 100 completed per FY 2014-2015 (average for the four quarters was an overall 94.1%)

Rapid Safety Feedback is a process designed to flag key risk factors for in-home services cases that could gravely affect a child’s safety. These factors have been determined based on reviews of other cases where child injuries or tragedies have occurred. Factors include but are not limited to the parents’ ages, the presence of a boyfriend in the home, evidence of substance abuse, previous criminal records, and prior abuse history. The critical component of the process is the case consultation in which the reviewer engages the child’s case manager and the supervisor in a discussion about the case.

Quarter 1, the Sarasota Y/ Safe Children Coalition completed a total of twenty-four (24) Rapid Safety Feedback reviews.
Quarter 2, The Sarasota Y/ Safe Children Coalition completed a total of twenty (20) Rapid Safety Feedback reviews.
Quarter 3, The Sarasota Y/Safe Children Coalition completed a total of thirty-four (34) Rapid Safety Feedback reviews.
Quarter 4, The Sarasota Y/Safe Children Coalition completed a total of eight (8) Rapid Safety Feedback reviews.

Highlighted Strengths:

- Services to Prevent Removal – referrals were located based on each family’s individual needs. Follow up was documented with service providers to ensure engagement of the families and their willingness to continue to accept the services.
- Initial and Ongoing Assessments – formal and informal assessments were documented in the case files. Risk was assessed to be appropriate for each individual case.
- Background Checks and Home Assessment – background checks and initial and updated home studies were completed as required and located in the files.
- Caseworker Visits with Child – documentation noted case managers speaking to the child (ren) alone. Visits were also done in the community such as daycare, schools, etc. Visits were based on the determination of risk.
- Caseworker Visits with Parents – documentation was located of quality visit with parents. Documentation included discussions of case plan and case progress.

Areas of Opportunities:

- Safety Planning / Monitoring the Safety Plan – there was documentation of development of safety planning with the families. However, there was limited information located with the case manager discussing follow up as to the safety plan during home visits. Sometimes there was discussion to ensure the safety plan
was still appropriate. When conditions in the home changed at times the safety plan was not re-evaluated to reflect the new conditions.

- Safe Case Closure – an identified gap in safe case closure was there are not enough wrap-around services to assist parents who were identified to have substance abuse issues.
- Supervisory Case Consultation – although supervisory consultations have improved over the past year there is still a struggle with supervisors “copying and pasting” previous supervision logs. Another is ensuring the follow up directives are completed timely by case managers.

Permanency: Fifty (50) completed per FY 2014-2015

Permanency reviews focused on nine (9) questions relating to the permanency goal, the ability of a child to maintain important connections within their families and communities, and with the ability to locate and place a child (ren) with relatives. Permanency was divided into two outcomes – Outcome 1 and Outcome 2.

Quarter 1, the Sarasota Y/Safe Children Coalition completed a total of fifteen (15) Permanency reviews.
Quarter 2, The Sarasota Y/Safe Children Coalition completed a total of fifteen (15) Permanency reviews.
Quarter 3, The Sarasota Y/Safe Children Coalition completed a total of eight (8) Permanency reviews.
Quarter 4, The Sarasota Y/Safe Children Coalition completed a total of eleven (11) Permanency reviews.

Permanency Outcome 1 (average for the four quarters was an overall 91.6%):

Highlighted Strengths:

- Frequency of contact with the child and family were sufficient – documentation reflected case management discussions regarding case plan progress with the family during contacts. Contacts reflected that the case managers were meeting the needs of the child (ren) as well as the parents.
- Background checks and home studies were sufficient and responded to appropriately – background checks were located in the files when required. Home studies were completed timely.

Opportunity for Improvement:

- Case plans did not always reflect the appropriate goal for the child to achieve permanency.
Permanency Outcome 2 (average for the four quarters was an overall 95.72%)

**Highlighted Strengths:**

- Regular Supervisory consults with the case manager – documentation was found that regular supervisory consults were held timely and within the organizations policy requirements of every thirty days.
- Concerted efforts were made to locate relatives when appropriate – case managers have all been trained on Family Finders. Case managers have made it a priority to ensure all out of home care licensed cases are referred to the family finders program, not only for placement but for a relationship/connection to the biological family.
- Concerted efforts were made promote, support, and/or maintain positive relationships between the child in out of home care and their families – case file reviews supported the efforts of the case managers trying to promote, support, and maintain important relationships of a child in out of home care. This includes documentation the case manager obtained background checks on teachers, coaches, and extended family members.

**Opportunity for Improvement:**

- Supervisory Case Consultation provided additional guidance – although case consults were occurring timely and were within the organizations policies the logs reflected “copying and pasting”, extending time frames on critical documents and at times were not updated to reflect current case progress.

**Well-being: Fifty (50) completed per FY 2014-2015**

Well-being reviews focused on seven (7) questions relating to the well being of a child in out of home care.

Quarter 1, the Sarasota Y/ Safe Children Coalition completed a total of fifteen (15) Well-being reviews.
Quarter 2, The Sarasota Y/ Safe Children Coalition completed a total of fifteen (15) Well-being reviews.
Quarter 3, The Sarasota Y/Safe Children Coalition completed a total of eight (8) Well-being reviews.
Quarter 4, The Sarasota Y/Safe Children Coalition completed a total of eleven (11) Well-being reviews.
Well-being Outcome 1 (average for the four quarters was an overall 94.96%):

**Highlighted Strengths:**
- Frequency of visits with the child and family were sufficient – documentation supported the case managers visits were appropriate to the identified risk level of the case or increased when needed to ensure the safety of the child.
- Concerted efforts were made to assess the needs of the children, parents, and foster parents – through case file reviews the children’s needs were being identified and referrals were being made to begin services.
- Efforts were made to involve the parents and children in case planning – documentation supported the involvement of the parents being part of the case planning process.

**Opportunity for Improvement:**
- Frequency and quality of visits between case worker and mothers/fathers were sufficient to ensure the safety, permanency, and well being of the children. The case workers were ensuring timely visits that were qualitative with the children and there appeared to be some limited visits with the mother/father during the out of home care period. Slim efforts were documented to visit with the mother/father but they were occurring timely or on a monthly basis.
- Concerted efforts were made to assess the needs of the children, parents, and foster parents – documentation supported the efforts made to ensure a child’s needs were met. However there was very limited documentation to support the needs of the parents or foster parents were assessed.

Well-being Outcome 2 (average for the four quarters was an overall 66.67%)

**Highlighted Strengths:**
- Efforts made to assess a Child’s educational needs – educational records were located in the files.

**Opportunity for Improvement:**
- This outcome was noted as a strength. However, when the child required tutoring or some specialized service regarding their education, referrals were not made, and follow up was not documented.

Well-being Outcome 3 (average for the four quarters was an overall 91.50%)

**Highlighted Strengths:**
- The agency addressed the physical health needs of the child, including dental – medical and dental records were located in the electronic filing system. Medical
tab in FSFN was updated and maintained in regards to physicals and dental appointments. Efforts to obtain records were documented by the case worker.

**Supplemental Quality Reviews for the FY 2014-2015:**

**Supervisory Consults:**

There were a total of one-hundred and ninety-two (192) supervisory reviews completed during the FY 2014-2015.

Supervisory consults was an area of concern during the FY 2013-2014. Reviews showed pertinent issues were discussed and reviews were documented, however, they did not always occur timely and they did not always show documentation of follow through. Reviews often missed opportunity to provide direction that would have resulted in case movement toward permanency, planning, and during transitional periods.

During the FY 2014-2015 supervisory reviews improved and reviews reflected a qualitative discussion was occurring in regards to case progress. Consults were timely and provided directives with time frames for completion. Although there has been progress with Supervisory consults there is still improvement needed in the areas of entering the completion of the supervisory consults into FSFN within the 48 hour requirement, moving away from the “copy and paste” of previous supervision logs and ensuring directives are completed and not extended from previous supervision to next supervision and so on.

**Psychotropic Medications:**

There were a total of forty (40) Psychotropic Medication reviews completed during the FY 2014-2015.

Psychotropic Medications is another area were improvement has been made in regards to maintaining and updating the medication tab in FSFN, with ensuring consent is received or a court order and timeliness of psychiatric appointments. Opportunities for improvement still remain with encouraging the parents to be an active participant in determining decisions regarding the child’s Psychotropic Medications. Obtaining medication logs monthly from caregivers and discussing Psychotropic medications during home visits with the child (if age appropriate) and the caregiver is also an area to improve.

**Safe Case Closure:**

There still appears to be concerns in individualized case planning matching to the child and family needs that include a realistic, long-term view toward safe case closure.

The 2014-2015 Quarterly performance goal for the Sarasota Y/ Safe Children Coalition was the “percentage of children reunified who re-entered out of home care within 12
months of the latest removal shall not exceed 9.90%”. The Sarasota Y/ Safe Children Coalition met the requirements ending the FY 2014-2015 year with a 6.5%.

**Child and Family Service Reviews:**

The Sarasota Y/ Safe Children Coalition completed eight (8) CFSR’s during the FY of 2014-2015. The CFSR’s were used to begin training Quality Management Staff on how to complete the Federal review and enter the review into the Federal CFSR portal. The reviews were completed by reading the case file, as well as interviewing stakeholders. Currently, at the time of Quarter 4 closing there were no reports available to run in regards to determining trends for strengths or opportunities.

Due to the reports not being accessible Quality Management staff completed debriefing forms that indicated the strengths of a case as well as the opportunities. These debriefing forms where shared with the case manager and the case manager supervisor.

The findings were the same as the Safety, Permanency and Well-being outcomes.

**Addressing Findings:**

The Sarasota Y/ Safe Children Coalition continues to address the issues identified by analysis of findings through quality improvement systems currently in place. These include the following processes and components:

- Analysis of Performance Measures
- Identification of root causes
- Implementation of performance improvement plans
- Continuous Quality Improvement Meetings (CQI)

The following areas will be the focus of quality improvement activities for the FY 2015-2016:

- Assure follow up directives are not extended month to month during supervision
- Safety Plan training
- Safety Plan Monitoring
- Improve monitoring of parent visits

The Sarasota Y/ Safe Children Coalition believes that to strengthen our system of care we must continually strive to exceed our establish outcomes, improve the quality of our services and address substandard performance.

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