Juan F. v Rell
Exit Plan

Civil Action No. H-89-859 (AHN)

Exit Plan Outcome Measures
Summary Report
Fourth Quarter 2006
October 1 – December 31, 2006

February 2007

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Exit Plan Outcome Measures
Summary Report
Fourth Quarter 2006

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February 15, 2007

Dear Mr. Mancuso,

It is with great pleasure that we submit to you our Fourth Quarter 2006 Exit Report. This report shows another noteworthy quarter in which the Department has met 16 out of 20 measures reported during the period. For the first time, all three permanency outcomes (reunification, adoption, and transfer of guardianship) achieved their goals, once again demonstrating the clear intent and efforts to improve our overall work with children and families.

Much has transpired in the three years since we submitted our first quarterly report. At that time, only a few of the outcome measures were automated, several were conducted through case reviews and some measures were in development. As of this most recent quarterly report, 17 outcome measures are automated reports, one is an administrative report, and four are case reviews.

The targeted focus on the outcome measures have aided in our significant improvements in our data reporting, data analysis, and quality improvement systems. We believe the Department's enhancement in these critical areas have allowed for an increased ability to evaluate of our management systems and case practice. We are able to identify the current population of children and families we serve, examining entries into care, length of stay, placement stability, sibling placement and issues effecting disproportionality. Managers, supervisors, and social workers are now able to track and manage case work (with an ability to "drill down" from area office to the worker level), identify areas needing improvement and highlight areas of strength. Much of this information is communicated at management, staff, and supervisory meetings creating many opportunities for special reviews and workgroups.

Much of the efforts put forth by our staff continue to be demonstrated in our quarterly outcome measures. However, it is necessary to acknowledge that much work continues to lie ahead. Particularly, in the areas of repeat maltreatment, foster care, and treatment planning. As our reporting environment becomes increasingly sophisticated, we are confident that the solutions are not far beyond our reach or sustainability.

Credit goes to the Department's staff who have embraced results-based management bringing us closer to moving beyond the Exit Plan and demonstrating our ability to continuously examine and improve how we serve the many families and children in Connecticut.

Respectfully,

Darlene Dunbar, MSW
Commissioner

Fourth Quarter 2006 Exit Plan Report
Commissioner Highlights

The Fourth Quarter 2006 Exit Plan report clearly demonstrates that three years of intense effort and focus on the reforms supported by the Juan F. Exit Plan is significantly benefiting the children and families the Department serves. Advances in day-to-day practice have consolidated improved outcomes in child safety, permanency, and well-being. The values that stand behind the outcomes are enmeshed into every aspect of our staff's work, and the Department is beginning to see the positive results that come from a staff culture that is child centered and family focused. Increasingly, our clients experience a staff whose work supports and partners with families, engages in thorough assessments and planning, and meets individualized needs.

This cultural shift has supported consistency in achieving many of the Exit Plan outcomes. Twelve outcomes have been achieved each quarter for a full year. Six of these have been achieved consistently over two full years. Eight outcomes have been met for six or more consecutive quarters. Overall, the Department met 16 of 20 outcomes in the Fourth Quarter, one less than the high of 17 outcomes achieved last quarter. (Two outcomes, treatment plans and needs met, are now reported directly from the Office of the Court Monitor and these reports were not prepared at the time of this writing.) Three more outcomes (repeat maltreatment, re-entry into care, and appropriate discharge of children with mental health and mental retardation treatment needs) reached within 3 percent of the goal and have fluctuated slightly from quarter to quarter.

Important milestones were also reached during the Fourth Quarter. For the first time, all three measures of timely permanency (reunification, adoption and subsidized guardianship) achieved goals. Workers in both in home and out of home cases not only met goals for visitation -- they reached the highest performance under the life of the Exit Plan. Best performances also were attained in reducing maltreatment in care, timely transfer of guardianship, and the timely provision of multi-disciplinary exams.

ACCOMPLISHMENTS

This quarterly report shows we met the following 16 outcomes:

- Commencement of Investigations: The goal of 90 percent was exceeded for the ninth quarter in a row with a current achievement of 95.5 percent.
- Completion of Investigations: Workers completed investigations in a timely manner in 93.7 percent of cases, also exceeding the goal of 85 percent for the ninth consecutive quarter.
- Search for Relatives: For the fifth consecutive quarter time, staff achieved the 85 percent goal for relative searches and met this requirement for 91.4 percent of children.
- Maltreatment of Children in Out-of-Home Care: The Department sustained achievement of the goal of 2 percent or less for the twelfth consecutive quarter with an actual measure of 0.2 percent, the best performance under the Exit Plan.

- Timely Reunification: For the sixth consecutive quarter, this measure exceeded the 60 percent goal with a mark of 61.3 percent.
- Timely Adoption: For the third of the last four quarters, staff exceeded the 32 percent goal for finalizing adoptions within two years of a child's entering care by meeting the goal in 33.6 percent of adoptions in the quarter.
- Timely Transfer of Guardianship: For the second consecutive quarter and the fourth of the last seven quarters, staff exceeded the 70 percent goal for achieving a transfer within two years of a child's removal with a performance of 76.4 percent, the best under the Exit Plan.
- Multiple Placements: For the eleventh consecutive quarter, the Department exceeded the 85 percent goal with a rate of 95 percent.
- Foster Parent Training: For the eleventh consecutive quarter, the Department met the 100 percent goal.
- Placement within Licensed Capacity: For the second consecutive quarter, staff met the 96 percent goal with an actual rate of 96.4 percent.
- Worker-To-Child Visitation In Out Of Home Cases: Staff reached their highest level of performance ever and exceeded the 85 percent goal for visitation of children in out-of-home cases for the fifth consecutive quarter by hitting the mark in 94.7 percent of applicable cases.
- Worker to Child Visitation in In-Home Cases: For the fifth consecutive quarter, workers met required visitation frequency in 89.2 percent of cases, thereby exceeding the 85 percent standard. This is the highest percentage of applicable cases where visitation standards were met under the Exit Plan.
- Caseload Standards: For the eleventh consecutive quarter, no Department social worker carried more cases than the Exit Plan standard.
- Reduction in Residential Care: For the third consecutive quarter, staff met the requirement that no more than 11 percent of children in DCF care are in a residential placement. As of January 30, 2007, there were 201 fewer children in residential care than in April 2004 – a reduction of 22.6 percent.
- Discharge Measures: For the sixth consecutive quarter and the seventh time overall under the Exit Plan, staff met the 85 percent goal for ensuring children discharged at age 18 from state care had attained either educational and/or employment goals by achieving an appropriate discharge in 100 percent of applicable cases. This is the second consecutive quarter the Department reached this level of performance in the Exit Plan's history.
- Multi-disciplinary Exams: For the fourth consecutive quarter, staff met the 85 percent goal by ensuring that 94.2 percent of children entering care received a timely multi-disciplinary exam, the highest level under the Exit Plan.

More important than this list of 16 goals met in the quarter is that staff has maintained this high performance over a sustained period of time. The improvements have been made a part of the fabric of their work even in the more challenging outcome areas. For example, the reduction in the reliance on residential placements, which, at the outset of the Exit Plan, was considered a very difficult goal to reach, has met the goal for three consecutive quarters. Compared to April 2004, 186 fewer children are reliant on a residential setting to receive needed treatment as of February 5, 2007, a reduction of 20.9 percent. The staff's hard work in instituting structural and service developments are having a sustained impact.

One of these developments is the Managed Service System (MSS), which operates in each area office and the Central Office and continues to plan on a child-specific basis to ensure that individual children receive treatment in the most appropriate setting and that as many children as possible remain in community settings. Therapeutic group homes have opened in 37 locations and have enabled many children who were previously in more restrictive levels of care to live in the community. These group homes also have contributed to staff's success in returning 201 children who were out of state for treatment since September 2004 -- a 40 percent reduction, according to data for January 1, 2007.

Another vital structural element, the Administrative Services Organization (ASO), began operation in January 2006 and provides useful information about specific children and how effective services are in meeting their individual needs. The ASO also is generating important data to help identify needs for specific types of services in identified parts of the state to that we can build a stronger overall service system. Despite the successes and initiatives that have contributed to them, the Department is aware that the appropriateness of placements in general continues to be one of the most important issues and challenges facing our work.

Similarly, timely permanency is vitally important matter for the children we serve, and while the Department has made considerable strides, it remains an area that demands innovation, improvement, and intense effort and focus. It is encouraging to note that this is the first quarter in which all the permanency measures, including reunification, adoption and subsidized guardianship, met goals for timeliness. Also encouraging is the overall trend: in the last six quarters, the three permanency measures reached the goal a total of 13 times out of a possible 18. The Multi-Disciplinary Assessment for Permanency (MAP) system has undoubtedly contributed to improvements that have seen staff meet the adoption goal in four of the last six quarters compared to the first six quarters under the Exit Plan when the goal was never reached and the goal for subsidized guardianship in four of the last seven quarters after failing to meet the goal in the first five quarters. Despite important improvements, the system remains challenged to find permanent homes for all our children in a timely manner.

Equally important to the overall progress to date is that the Department continues to develop its capacity for quality improvement. An important management tool that is assisting the Department evaluate its work in a timely manner is the Results Oriented Management (ROM) data reporting system, which is accessible to all Department staff. ROM supports managers and supervisors in their quality improvement decisions in the area offices as well as to identify and examine the strengths and challenges in everyday practice and its documentation. There are now 12 outcome measures that are captured by ROM, thereby enhancing managers' ability to see performance in a timely manner across the spectrum of our work. ROM allows Department staff to view data with greater flexibility, including the ability to view work over longer periods of time as well as to "drill down" into the work of particular units and staff.

CHALLENGES

Despite impressive accomplishments by our staff in improving the quality of services offered to children and families, the Department continues to grapple with significant issues that must be resolved to meet all of our responsibilities as a helping agency. Because families themselves are the most important resource for children, the Department must do more to work as partners with parents and caregivers, to assess individual children's needs and then plan and offer services that meet those individualized needs, and to find homes for children who can live in families. In addition, the Department must continue to improve how it secures appropriate and stable placements – in the community when possible and only as long as required -- for those children whose treatment needs preclude family living.

In addition to resources for suitable and stable placements, the Department continues to be challenged in relation to comprehensive treatment planning and the outcome measure for meeting children's needs. As has been the case for the last three years, these issues are long-standing concerns that go to the foundation of our work with children. For that reason, there will be no quick-fixes or easy answers. Rather the Department is undertaking a broad approach to these fundamental aspects of social work across a broad variety of areas.

Following is an update on a number of initiatives that will improve assessments, treatment plans, and case decisions include the following:

- **Structured Decision Making (SDM)**: SDM is an evidence-based approach to delivering child welfare services proven to be both valid and reliable. The decision to open a case for ongoing services is based upon an actuarial assessment of risk that is not individually predictive but assigns categories of risk based upon the family circumstances. Importantly this de-links case opening from an underlying substantiation, distinguishes safety from risk, and has tools that focus workers on assessing family strengths as well as needs. This will produce greater consistency in our work and will help in targeting resources to where they can be most effective. Importantly, this consistency offers one way to mitigate the disproportionality seen in child welfare in Connecticut and across the nation. All staff will be trained starting January 2007 and ending by April 2007. As of early February, 420 managers and supervisors as well as 300 social workers received the training. Hotline staff started using SDM in January 2007. Full implementation will take place as the training rolls out through the offices.

- **Global Appraisal Of Individual Needs (GAIN)**: GAIN is an evidence-based tool that was primarily designed for assessing treatment needs related to substance abuse. There are multiple versions that are essentially subsets of the full GAIN and are valid and reliable instruments. In cooperation with the UCONN Health Center, a nationally certified GAIN trainer continues in the process of training our investigation staff to employ the GAIN Short Scale as a part of our investigation protocol in all cases. Two offices, Bridgeport and New Britain, have been trained and are using the GAIN assessments. All other offices have begun training, and Intensive Family Preservation (IFP) providers have completed their training.

Initiatives that will improve how we deliver services include the following:

- **Differential Response**: A recognized "promising practice" in child welfare that has been piloted in the Hartford community for the past 2 years. This approach is expected to be taken statewide in State Fiscal Year 2009 and the interim period is being dedicated to planning, policy and implementation readiness. DRS utilizes a non-blaming, strength-based, assessment approach to engage families in identifying needs for the majority of accepted reports to the Hotline. There is no associated substantiation or placement of any adult on the Central Registry. The traditional forensic-based approach of a CPS investigation will be utilized only for those cases indicating serious injury or risk of immediate harm to a child. Available research indicates better child welfare outcomes with this approach with no attendant increase in instances of child maltreatment.

- **Intensive Safety Planning (ISP)**: ISP is designed to provide intensive, concrete, home-based services with select families immediately upon removal of a child through a court order. The focus is on mitigating the safety factors that led to the removal in order to consider prompt reunification before the 20 day Order of Temporary Custody hearing. Two evidence-based practices will be utilized as part of the ISP intervention, including the Structured Decision Making (SDM) Safety Assessment Tool (completed by DCF staff during the initial investigation and before the decision to remove is made as well as before reunifying the child). In addition, the Global Appraisal of Individual Need (GAIN)-Quick tool will be administered to the primary caretaker during the ISP intervention in order to identify the constellation or behavioral health, medical or other treatment issues. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services.

Initiatives that will improve specific services offered to children and families include the following:

- **Building Stronger Families**: An evidence-based, integrated, in-home model for helping families with parents who need substance abuse treatment and children over the age of seven who have suffered maltreatment and have mental health treatment needs. The Annie Casey Foundation supports this approach, which currently is being piloted in New Britain and is a modification of the MST model. Services are being expanded to New Haven, with training there currently underway and expected to be completed in February 2007. Services in New Haven are expected to begin in March.

- **Intensive Home Based Services aka "Family-Based Recovery" Treatment (for substance abusing parent)**: Similar to Building Stronger Families except the children are under age two, Family Based Recovery Treatment targets substance abuse of parents and maltreatment issues. This in-home substance abuse treatment program focuses on parenting skills and repairing parent/child attachment issues. Services began in New Haven in January 2007 and other three additional regions are preparing to begin services in March. The last of the five regions to gain a provider was awarded a contract and will start services in April 2007. Each of the five programs will serve 12 families at a time.

- **Project SAFE Outreach And Engagement**: Now in Hartford and New Haven, this program will become a component of ISP (see above) when ISP becomes operational. Case managers work in the home to address substance abuse. High participation is anticipated in contrast to traditional Project SAFE outcomes.

- **Supportive Housing for Families**: The Supportive Housing for Recovering Families Program (SHRF) offers family support services and safe housing to families involved with DCF. The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF. Housing is funded through a combination of DCF funds, DSS Rental Assistance Program (RAP) certificates, and federal Section 8 Housing Vouchers. The program was recently expanded (July 06) to serve an additional 100 families increasing the total program capacity to 465 families.
- **Short-Term Assessment Resource (STAR) Centers**: STAR Centers are now replacing the outdated shelter system across Connecticut. Instead of reliance on traditional shelters, which have struggled to meet the changing needs of children, "STAR" Centers around the state will offer treatment and support planning for a more effective course of care. The new system will have capacity to serve 84 children through 12 program sites across the state. Eight of those sites have been secured and the remaining four are in process.

In addition to this array of new approaches and programs, the Department is continuously looking to identify ways to overcome barriers to achieving better outcomes for children and families. Currently, the Department is conducting case reviews to examine a number of sub-populations of children to determine critical issues affecting their care and treatment and to find ways to improve our work. Among the reviews now underway is a study of children in sub-acute treatment settings to determine what can be done to serve them in a less restrictive level of care and in a more timely manner.

Another study examines ways to expedite the transfer of guardianship to relatives, when appropriate, by identifying barriers unique to their case circumstances, including identifying ways for continued re-assessment, and to encourage, maintain and support relative placements for children. In addition, the Department continues to conduct a more in-depth analysis of sibling placements and the reasons (clinical or non-clinical) they may be separated. Documentation has been a challenge and we continue to see improvements each quarter. However, the biggest challenge remains in the availability of foster homes – particularly those that can accommodate sibling groups of 3 or more within their own communities. The emphasis must continue to be in resolving barriers to relative placements, keeping siblings together, and ensuring children/youth are in the least restrictive settings – while maintaining roots within their communities. Despite these barriers, there are best practices influencing the improvements noted throughout the Exit Plan.

Another challenge relating to suitable and stable placements and achieving permanency for children relates to identifying foster care resources. Significant effort is being directed into this area, and a recently proposed, phased foster care plan addresses a number of issues including ensuring that quality standards for foster care are consistent across the state as well as improving

the retention, support and recruitment of foster parents, relative caregivers, and "like family" caregivers. Efforts to improve recruitment are already underway and include the use of "resident experts," who include children, existing foster parents and birth parents. These "experts" help recruit and support foster parents at open houses, PRIDE trainings, support groups, and in obtaining free media coverage about the need for and value of foster parenting. These efforts will continue to expand over the next 12 months. In addition, the University of Connecticut is completing research on public attitudes regarding foster care as well as on attitudes of current foster care to support efforts to recruit and retain this vital resource for our children.

Permanency goals and efforts to assess their appropriateness and feasibility in a timely manner must also remain in the forefront. Initiatives are underway to identify and study sub populations (e.g. children under 12, those with a goal of APPLA, use of compelling reasons and the resolution of these barriers) with a focus on regular and ongoing assessments, close tracking of timeframes to achieve permanency, strategies to improve our data quality and taking action on cases in need of additional attention. This added management oversight will help support statewide consistency, allow for targeted strategies and uncover systemic gaps impacting children in care.

CONCLUSION

The sustained progress is clear evidence that staff are focused on positive results for children and families as well as energized by the many reforms and improvements underway. At the same time, we recognize the great challenges that remain. Indeed, for the Department to reach its fullest potential, we must constantly be willing and able to identify the evolving and multi-dimensional issues that come from partnering with children, families and communities to promote child safety, permanence, and well-being. Thorough and comprehensive individualized assessments, effective planning, and successful interventions always will strain our capacity to achieve quality work if we insist – as we must – on a child-centered, family-focused practice. This is inherently difficult work, and we must acknowledge that and support our staff as they struggle against the challenges that will always come with it.

In acknowledging the ever changing barriers and opportunities this work presents, it is also true to note that Department staff and the quality of services it offers to children and families has reached its highest levels in the history of DCF, and we are poised and committed to doing even better.

4Q October 1-December 31, 2006 Exit Plan Report

Outcome Measure Overview

Measure	Measure	Baseline	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005	1Q 2006	2Q 2006	3Q 2006	4Q 2006
1: Investigation Commencement	>=90%	X	X	X	X	91.2%	92.5%	95.1%	96.2%	96.1%	96.2%	96.4%	98.7%	95.5%
2: Investigation Completion	>=85%	73.7%	64.2%	68.8%	83.5%	91.7%	92.3%	92.3%	93.1%	94.2%	94.2%	93.1%	94.2%	93.7%
3: Treatment Plans**	>=90%	X	X	X	10%	17%	X	X	X	X	X	X	54%	
4: Search for Relatives*	>=85%	58%	93%	82%	44.6%	49.2%	65.1%	89.6%	89.9%	93.9%	93.1%	91.4%	5/15/07*	8/15/07*
5: Repeat Maltreatment	<=7%	9.3%	9.4%	8.9%	9.4%	8.9%	8.2%	8.5%	9.1%	7.3%	6.3%	7.0%	7.9%	7.9%
6: Maltreatment OOH Care	<=2%	1.2%	0.5%	0.8%	0.9%	0.6%	0.8%	0.7%	0.8%	0.6%	0.4%	0.7%	0.7%	0.2%
7: Reunification*	>=60%	57.8%	X	X	X	X	X	X	64.2%	61%	66.4%	64.4%	62.5%	61.3%
8: Adoption	>=32%	12.5%	10.7%	11.1%	29.6%	16.7%	33%	25.2%	34.4%	30.7%	40.8%	36.9%	27%	33.6%
9: Transfer of Guardianship	>=70%	60.5%	62.8%	52.4%	64.6%	63.3%	64.0%	72.8%	64.3%	72.4%	60.7%	63.1%	70.2%	76.4%
10: Sibling Placement*	>=95%	57%	65%	53%	X	X	X	X	96%	94%	75%	77%	83%	85.5%
11: Re-Entry	<=7%	6.9%	X	X	X	X	X	X	7.2%	7.6%	6.7%	7.5%	4.3%	8.2%
12: Multiple Placements	>=85%	X	X	95.8%	95.2%	95.5%	96.2%	95.7%	95.8%	96%	96.2%	96.6%	96.8%	95%
13: Foster Parent Training	100%	X	X	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
14: Placement Within Licensed Capacity	>=96%	94.9%	88.3%	92.0%	93.0%	95.7%	97%	95.9%	94.8%	96.2%	95.2%	94.5%	96.7%	96.4%
15: Needs Met**	>=80%	X	53%	57%	53%	56%	X	X	X	X	X	X	62%	
16: Worker-Child Visitation (OOH)*	>=85% 100%	Monthly Quarterly	72% 87%	86% 98%	73% 93%	81% 91%	77.9% 93.3%	86.7% 95.7%	83.3% 92.8%	85.6% 91.9%	86.8% 93.1%	86.5% 90.9%	92.5% 91.5%	94.7% 99.0%
17: Worker-Child Visitation (IH)*	>=85%	X	39%	40%	46%	33%	X	81.9%	78.3%	85.6%	86.2%	87.6%	85.7%	89.2%
18: Caseload Standards+	100%	69.2%	73.1%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%
19: Residential Reduction	<=11%	13.5%	13.9%	14.3%	14.7%	13.9%	13.7%	12.6%	11.8%	11.6%	11.3%	10.8%	10.9%	11%
20: Discharge Measures	>=85%	61%	74%	52%	93%	83%	X	X	96%	92%	85%	91%	100%	100%
21: Discharge to DMHAS and DMR	100%	X	43%	64%	56%	60%	X	X	78%	70%	95%	97%	100%	97%
22: MDE	>=85%	5.6%	19.0%	24.5%	48.9%	44.7%	55.4%	52.1%	54.6%	72.1%	91.1%	89.9%	86%	94.2%

Results based on Case Reviews

OM	Comments
1, 2, 4, 5, 7, 8, 9, 10, 11, 16, 17 & 22*	***ROM Reports*** ** ROM report with supplemental case review, conducted by Results Management, to evaluate and confirm clinical reasons for separating sibling groups.*
4	*ROM report posted for 4Q 2006 reflecting status of children entering care for the 2Q 2006 period. This is consistent with the Exit Plan measure definition. Refer to 1Q 2006 column.*
*6, 12, 14, 18 & 19**	***LINK Reports*** **LINK report with supplemental case review, conducted by Behavioral Health, examining the sub-acute population.*
3+, 13, 15+, 20** & 21**	***Case Reviews*** *+Court Monitor and DCF collaborative in depth case review* **Administrative Report from CAFAP* ***Case Review conducted by DCF Continuous Quality Improvement Division*

Treatment Plans**

** Conducted by the Court Monitor's Office and DCF.

2006

1Q N/A
2Q N/A
3Q 54% (refer to Court Monitor's Report for results of their case review)
4Q

2006

In addition, two (2) additional areas were evaluated: Treatment plan must be written and treatment conference conducted in the family's primary language and treatment plans developed in conjunction with parents/child/service providers (for example, treatment plan modifications as a result of input from the ACR).

1Q N/A
2Q N/A
3Q 100% (refer to Court Monitor's Report for results of their case review)
4Q

Caseload Standards +

2006

1Q As of May 15, 2006 the Department met the 100% compliance mark. The sixty (60) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

2Q As of August 15, 2006 the Department met the 100% compliance mark. The thirty (30) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

3Q As of September 30, 2006 the Department met the 100% compliance mark. The forty (40) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

4Q As of December 31, 2006 the Department met the 100% compliance mark. The fifty-three (53) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
1. Commencement of Investigation: *to assure that assessments of safety can quickly be determined and increases collaborative interviewing and intervention.* 90% of all reports must be commenced same calendar day, 24 hours or 72 hours depending on referral code.	**2006** **4Q – 95.5%**	ROM report	**A)** Developed LINK capacity to document and measure commencement time and modifications to commencement time. Provided corresponding LINK training to staff.	Completed
			B) Revision of policy #34-3-3 "Conducting the Investigation"- To direct that the Social Work Supervisor can approve modification of commencement times. Previously, Program Supervisor approval was required and was inefficient.	Completed.
			C) Area Offices use LINK data reports to assess staffing levels in investigations and take any supervisory or practice improvement steps necessary to ensure performance goals.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
2. Completion of Investigation: *to assure that case assessment and disposition is handled in a timely manner.* 85% of all reports shall have their investigations completed within 45 calendar days of acceptance.	**2006** **4Q – 93.7%**	ROM report	**A)** Implement a quality review process in each Area Office that serves as a tickler system at 28, 35, and 40 days and calls for any corrective action plans.	Completed.
			B) Developed a quality review process for the Special Investigations Unit through Hotline.	Completed.
			C) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Developed standards for the release of information that assists with the sharing of information between DCF and community providers and/or other state agencies.	Completed.
			F) The department proposed legislation requesting a change in the statutory requirement of completing investigations within 30 days. This request change extended the statutory requirement to 45 days to comport with the Exit Plan.	PASSED: Effective October 1, 2005. Staff informed via all staff Commissioner e-mail and via the newly developed SWS Guide to Exit Plan and Practice Points.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
3. Treatment Plans: *to provide a family-centered foundation from which all case service planning will occur-timeframes, roles and responsibilities-and a means for assessing service outcomes and needs met.* Within 60 days of case opening in treatment, or 60 days from date of placement- whichever comes sooner. Random reviews done by DCF and Court Monitor.	**2006** **4Q –%**	Case Review	**A)** Train and implement in all area offices on the agency's new Family Conferencing Model, develop & implement a method to evaluate its success and/or areas needing improvement through feedback from families, staff, management and providers.	Phase II in process which involves consultation and coaching for all Area Offices, outreach to Behavioral Health partners, and development of a partnership with Area Office Domestic Violence consultants (Novemeber 2006). December 2006 expected completion of Family Conference Evaluation Report. Development of a Family Conference Training Video underway with an expected completion date of January 2007.
			B) Develop a web-based Uniform Case summary-prototype that provides a quick case summary view and helps to improve data entry.	Released September 2006.
			C) Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering committee established.	Training and implementation of SDM by trained staff began January 28, 2007. Training of all DCF staff by April 2007.
			D) The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing.
			E) Continue to advance major training activities treatment planning and concurrent planning and modify current LINK screens for Treatment Plans and enhance methods for case documentation (short-term=Pilot; long term=SharePoint Pilot testing new template and tool underway).	Concurrent Planning Training completed for social work supervisors and managers; make-up sessions at the Training Academy currently scheduled. Treatment Planning Training completed for the newly revised guide.
			F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			G) Area offices have broadened the consultation capacity of the Area Resource Group to assist in the development of a treatment plan for complex cases requiring significant supports (i.e. Parents with Cognitive Limitations, Medically Complex cases, etc.).	Domestic violence specialists have been added to the hiring of Global Assessment Specialists. Domestic violence consultants hired and trained December 2006.
			H) Expand Area Office's capacity of teleconference for the ACR process into the Family Conferencing arena placed in Newsletter and foster parent pay checks.	Completed.
			I) Train Area Office staff, particularly Social Work Supervisors, on the treatment plan elements necessary under the Exit Plan, methods and practices useful to successful treatment planning. Newly revised and comprehensive Treatment Plan Guide developed. Developed tools and guidance to assist staff in integrating treatment planning into worker/client visits and supervisory conferences.	Completed and included in SWS Guide. Completed the development of a structured treatment plan (tools and process) for use by area offices (optional use). Dissemination to all staff Fall 2006.
			J) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
4. Search for Relatives: *to increase the availability of supports for children consistent with the goal of keeping them within their community and in maintaining lifelong family ties*. DCF shall conduct searches for relatives, extended or informal networks, friends, family, former foster parents or other significant persons known to the child. Must be documented in LINK.	**2006** **4Q – 91.4%** Data reflects 2006 Qtr 2 due to a 6-month lag	ROM report	**A)** Implemented the Placement Resource Search window in one central place in LINK for accurate and easily accessible documentation of placement resource search efforts and institute tickler system at fifth month to identify those cases that do not have a window.	Completed. Exception "tracking" report posted on intranet and created for use by the area office staff.
			B) Use family conferencing model to assist in the identification of appropriate relative resources early on in the life of the case.	Ongoing.
			C) Revise Search – Requests for Identifying Information policy (41-40-8) and Affidavit	Awaiting approval.
			D) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			E) Started Casey Family Programs Supporting Kinship Care Collaborative in the Bridgeport area office.	Completed.
			F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			G) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
5. Repeat Maltreatment: *to reduce incidents of maltreatment and maintain and provide services to children in order for them to remain with their families and in their communities.* No more than 7% of children who are victims of substantiated maltreatment during a 6-month period shall be the substantiated victims of additional maltreatment during a subsequent 6-month period.	**2006** **4Q – 7.9%**	ROM report	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing 12 Exit Outcome reports and addition related (exception reports). All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.
			B) Increase the consistency of handling and identifying repeat maltreatment via training and supervision. Correspondingly review and revise policy to reflect practice.	Completed and ongoing.
			C) Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering Committee established.	Implementation target for January 2007.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			E) Critical Response Reviews/Special Case Reviews Study (CRR/SCR) committee established to look at patterns of incidents, agency process and procedures, and if any training/practice improvement steps are necessary.	Currently a database has been established to collect all findings from the CRRs and SCR (conducted by Child Welfare League of America). Results are used to inform Area Office management teams.
			F) Parent/Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS assigned to all area offices.
			G) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			H) Develop new Intensive Reunification Services through RFP to offer an array of services to families along a continuum that promotes reunification/permanency for children using federal funds.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			I) Expanded intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion. (July 2007) – for additional 1.2 million.
			J) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
6. Maltreatment in care - Out-of-home: *to assure children's safety while in out-of-home care, improve placement stability, and reduce additional trauma.* No more than 2% of children in out of home care shall be the victims of substantiated maltreatment by substitute caretaker.	**2006** **4Q – 0.2%**	LINK report	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing 12 Exit Outcome reports and addition related (exception reports). All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing
			B) Moved Special Investigations management from Hotline to a direct report under Bureau Chief for Child Welfare. In addition, to provide consistency with investigating and tracking of foster care maltreatment, reports of abuse/neglect concerning foster families have been moved to the Special Investigation Unit and are now centralized.	Completed.
			C) Develop and implement a corrective action plan protocol for all regulatory violations and all out-of-home substantiations. Incorporate any corrective action plans into Foster Family Support Plan.	Completed.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
7. Reunification: *to reduce the length of time children are in care, minimize trauma from separation, allow opportunities for children to maintain connectedness to family and community, help parents safeguard their homes, and recognize the importance of expediting permanency planning.* 60% of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home.	**2006** **4Q – 61.3%**	ROM report	**A)** Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
			B) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			C) Expansion of Supportive Housing Contract – Connection Inc. by $2.1 million; increase capacity to serve 345 families in Hartford, Bridgeport, Danbury and Torrington areas. Establish priority access for family preservation/reunification referrals.	Completed. Connections (80 contract) provides quarterly and yearly reports. July 2006 received an expansion to serve 465 families.
			D) Implementation of formalized supervisory conference- SWS to discuss viability of current permanency goal for all children in OOH care at 3 months.	Assistant Bureau Chief for Child Welfare with technical assistance from IS and Results Management has developed a series of permanency management reports to better track and resolve barriers to achieving permanency. These reports are available through the DCF intranet site.
			E) Develop ROM reports to strengthen the tracking of Federal ASFA timelines (reunification within 12 months of most recent placement) and the identification of family/child characteristics or gaps in services that become barriers to the successful achievement of this outcome measure.	ROM is currently providing 12 Exit Outcome reports and addition related (exception reports). All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing
			F) Develop new Intensive Reunification Services through RFP to offer an array of services to families along a continuum that promotes reunification/permanency for children using federal funds. Targeted for Waterbury, Manchester.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			G) Expand intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion. (July 2007) – for additional 1.2 million.
			H) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			I) Ensure Flex Funds policy and guidelines support reunification efforts and post-reunification needs by meeting emergency needs that if not addressed result in crisis and often re-entry into care.	Completed.
			J) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			K) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			L) Parent/Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS programs assigned to area offices.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
			M) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those “stuck” in Emergency Departments.
			N) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
8. Adoption: *promotes and emphasizes permanency for children in out-of-home care, decreases trauma, and focuses DCF and courts in an effort to make adoptions more timely and successful.* 32% of the children who are adopted shall have their adoptions finalized within 24 months of most recent removal from home.	**2006** **4Q – 33.6%**	ROM report	**A)** Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			B) Continued reinforcement by permanency managers clarifying the "perceived wait period" for adoption finalization (staff was reporting that they had to "wait" 12 months after placement to finalize adoption--effort is aimed at clearing up confusion with the law).	Ongoing. 3 memos distributed between 2004 and May 2005 clarifying perceived wait period reinforcement of parameters to be completed by area office management.
			C) Decentralize the processing of finalizing adoptions. Each area office will be responsible for this function to streamline. Subsidy requests will continue to be processed through OFAS. Training and implementation completed.	Completed.
			D) Secured budget option to create greater incentives for adoption – including support to adoptive parents, tuition for college and enhanced SW training.	Implemented. Phase II in development. Policy updates completed and awaiting publication.
			E) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			F) Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support. Year-to-date there have been 97 recruited families, 39 pending licenses, 7 licensed families and 5 children placed.
			G) Data reports (i.e. LINK Reports, ROM tool and Chapin Hall) to track individual/unit performance, identify trends and target supervisory discussions for children in Out-of-Home care.	ROM is currently providing 12 Exit Outcome reports and addition related (exception reports). All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing
			H) Resource Family Development model to promote long-lasting support resources for children in out of home care. This effort promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.
			I) Revise Permanency Planning policy to standardize the approval process for selecting appropriate families for available children and ensuring successful and timely identification of adoptive parents.	Completed.
			J) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			K) Collaborative with Casey Family Services to increase adoption-competent mental health practitioners in the community to increase support for adoptive families.	Completed. Post-adoption support services available through UCONN Health Center.
			L) DCF contracted with CAFAP to operate KID HERO line to allow for longer hours and quicker turn around for foster parent inquiries.	Completed March 1, 2005.
			M) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
9. Transfer of Guardianship: *promotes and emphasizes permanency for children in out-of-home care, decreases trauma, and allows children to maintain connection with family.* 70% of all children, whose custody is legally transferred, shall have the guardianship transferred within 24 months of the child's most recent removal from home.	**2006** **4Q – 76.4%**	ROM report	**A)** Area Office Quality Improvement Plans to reflect areas for improvement and progress.	Ongoing.
			B) Implement a Licensing Review Team for consideration of waivers for relative caregivers who have been denied licensure due to substantiated CPS history and/or criminal history.	Completed.
			C) Revised subsidized guardianship policy (41-50-1 through 41-50-14) to reflect current practice and ASFA timeframes.	Completed.
			D) Revise Permanency Planning Team policy (48-14-6 through 48-14-6.5) to reflect the approval process for subsidized guardianships.	Finalized and distributed policy.
			E) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			F) Legislation passed that shortened the timeframe for relative foster care eligibility into the subsidized guardianship program to a minimum of 6 months (from 12 months) in placement.	Completed.
			G) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			H) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			I) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			J) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
10. Sibling Placement: *maintains life's longest lasting relationship, increases family connections, and decreases trauma.* 95% of siblings entering out of home placement shall be placed together unless there are documented reasons for separate placements.	**2006** **4Q – 85.5%** Data reflects 2006 Qtr 2 due to 6 months lag	ROM report (supplemental case review)	**A)** Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our sibling groups that will provide permanency using in-house, private contract and faith-based networks. Enhance contract support for specialized foster care recruitment.	Ongoing.
			B) Informed staff to use the definition and intent of outcome #10, what is used to define "sibling," and what is an acceptable therapeutic reason to not place siblings together.	Completed.
			C) Utilization of Flex Funds policy and guidelines support sibling placement efforts by meeting emergency needs.	Ongoing.
			D) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			E) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			F) Develop a Sibling Visitation Project to support monthly visits for separated, sibling groups in out of home care.	Area Offices have continued to utilize the $200,000 funds to support sibling visitation efforts and new funding for the upcoming fiscal year has been available.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
11. Re-Entry into DCF Custody: *to reduce incidents of maltreatment and the number of children in out of home care, and maintain and provide services to children in order for them to remain with their families and in their communities.* Of all children who enter DCF custody, seven (7) % or fewer shall have re-entered care within 12 months of the prior out of home placements.	**2006** **4Q – 8.2%**	ROM report	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing 12 Exit Outcome reports and addition related (exception reports). All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing
			B) Developed new Intensive Reunification Services through RFP that offers an array of services to families along a continuum that promotes reunification/permanency for children using federal funds. 2 Pilots in Manchester and Waterbury. Contract Awarded.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			C) Expand intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion. (July 2007) – for additional 1.2 million.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) An RFP was distributed and applications received for Parent/Child Centers which will provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS programs assigned to 10 area offices.
			F) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those “stuck” in Emergency Departments.
			G) Utilize Flex Funds to support reunification by meeting emergency needs to prevent crisis and/or re-entry.	Ongoing.
			H) Expansion of Supportive Housing Contract – Connection Inc. by $2.1 million; increase capacity to serve 345 families in Hartford, Bridgeport, Danbury and Torrington areas. Establish priority access for family preservation/reunification referrals.	Completed. Connections (main contract) provides quarterly and yearly reports. DCF monitoring program and in 2005 demonstrated a 90% success rate.
			I) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
12. Multiple Placements: *to promote stability and the reduction of incidence of trauma, to assure consistent services to children and further the goal of permanency.* At least 85% of the children in DCF custody shall not experience more than 3 placements during a 12-month period.	**2006** **4Q – 95%**	LINK report	**A)** Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support.
			B) Revise disruption conference policy (36-55-20) to utilize the Area Resource Groups at various stages in the life of the case.	Under review.
			C) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			D) Central Placement Team (CPT) enhancements to better manage available beds, improved placement determinations, not just based on level of care but on programming needs and to implement a no unilateral eject/reject policy for residential facilities and group homes is being instituted along with that reorganization to ensure placements.	Ongoing.
			E) Resource Family Development model to promote long-lasting support resources for children in out of home care. This effort promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.
			F) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those “stuck” in Emergency Departments.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
13. Foster Parent Training: *to increase the capacity of foster families to meet the needs of our children and to assure a sense of partnership and support.* Foster parents shall be offered 45 hours post licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. Does not apply to relative, special study or independently licensed foster parents- they require 8 hours pre-service.	**2006** **4Q – 100%**	CAFAP Report	**A)** Convened foster parent advisory group to evaluate pre and post licensing training. To be convened by POC lead twice a year to evaluate quarterly planning efforts by CAFAP.	Ongoing.
			B) Develop alternative methods for training (i.e. online), increase training for Spanish-speaking providers, use seminars or conferences in the community such as Board of Education, hospitals, & partner agencies. Sponsored events.	Ongoing. Current emphasis on improving communication materials and classes for Spanish speaking providers. CAFAP in process of translating flyers in Spanish.
			C) Developed training modifications based on CAFAP report and findings. In service was held on 2/21/05 for nine new trainees in areas where curriculum is needed for further development.	Ongoing.
			D) CAFAP will submit training certification data to Assistant Bureau Chief of Child Welfare for enhanced tracking of post-licensing training. This will ensure licensing completion.	Ongoing.
			E) DCF to develop other training avenue through the Training Academy and other sponsored training. CAFAP to promote through their areas of communication.	Ongoing. DCF training academy catalog classes now open to foster parent participation.
14. Placement within Licensed Capacity: *to reduce the level of stress that can result in disruption and maltreatment, to maintain stability of placement and reduce trauma, and to focus DCF in its effort to recruit foster families.* At least 96% of children placed in foster homes shall operate within their licensed capacity, except when necessary to accommodate siblings.	**2006** **4Q – 96.4%**	LINK report	**A)** Use family conferencing model to assist in the identification of appropriate relative resources early on in the life of the case.	Ongoing.
			B) Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support. Year-to-date there have been 97 recruited families, 39 pending licenses, 7 licensed families and 5 children placed.
			C) When there is a need to approve overcapacity placement the Department shall document the need and develop a support plan in LINK narrative for the home to assure stability.	Completed.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			F) Resource Family Development model to promote long-lasting support resources for children in out of home care. This strategy promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
15. Needs Met: *to prioritize service needs, identify service gaps, eliminate service redundancy, and facilitate access in order to assure a family's physical and emotional well-being and ultimately build their capacity as a family.* At least 80% of families' and children's medical, dental, mental health and other service needs as specified in the treatment plan must be documented in LINK.	**2006** **4Q – %**	Case Review	**A)** Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering Committee established.	Implementation targeted for January 2007.
			B) The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing in all area offices.
			C) Budget option approved to expand Intensive In-Home to offer an array of services to families along a continuum that promotes reunification/permanency for children and expand intensive in-home services such as, IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care.	Budget approved (July 2006) for a 1.2 million expansion. (July 2007) – for additional 1.2 million.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Pursuant to federal law, DCF has established a referral protocol for all children under the age of 3 involved in a substantiated CPS case to Birth to Three for evaluation.	Completed.
			F) Bi-monthly meetings with the MHPDs of ARG to involve, when appropriate, updates about new, expanded and available health care services to improve awareness and expedite access. Area offices have broadened the consultation capacity of the Area Resource Group to assist in the development of a treatment plan for complex cases requiring significant supports (i.e. Parents with Cognitive Limitations, Medically Complex cases, etc.).	Complete hiring of psychologists.
			G) Expand new diagnostic facilities by 5-14 to eliminate wait-lists and transportation barriers for children.	All up and running.
			H) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			I) Parent/Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS assigned to all area offices.
			J) Implement a no unilateral eject/reject policy for residential facilities and group homes	Completed.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
			K) Central Placement Team (CPT) enhancements to better manage available beds, improved placement determinations, not just based on level of care but on programming needs and to implement a no unilateral eject/reject policy for residential facilities and group homes is being instituted along with that reorganization to ensure placements.	Ongoing.
			L) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.
			M) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			N) *Shelter Re-Design* STAR Centers are now replacing the shelter system across Connecticut. "STAR" Centers will offer treatment and support planning for a more effective course of care.	The new system will have capacity to serve 84 children through 12 program sites across the state. Eight of those sites have been secured and the remaining four are in process.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
16, 17. Worker-Child Visitation- Out of Home/Worker-Child Visitation- In Home: *to establish an ongoing means to assess family status, including safety issues, and monitoring progress towards treatment plan goals.* #16: DCF shall visit at least 85% of children in out of home care at least once a month except for probate, interstate and voluntary. #17: DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases.	**2006** **4Q** **#16:** Monthly: 94.7% Quarterly: 99% **#17:** Quarterly: 85.7%	ROM report	**A)** Agreement reached with Court Monitor to allow for private agency SW's visits to count and for information concerning these visits to be documented in LINK. Clarify DCF representation and include visits made by FASU (Out-of-Home). Per Monitor Agreement, define the role of the ICPC and other "DCF representatives" in achieving visitation requirements.	Completed.
			B) Assignment of 5 positions to be posted to out-of-state residential facilities as the responsible party for visiting all the DCF youth in the assigned residential facilities. Role announced in March newsletter to staff.	Completed.
			C) To assure greater success for social workers in meeting the visitation requirements, achievement of caseload standards occurred August 15, 2004 and the receipt of 100 new state vehicles was acquired by November 1, 2004.	Completed.
			D) Re-establish the use of face-to-face contact narratives via a LINK build in December. "Attempted face to face no contact" via LINK build - April 2005.	Completed.
			E) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
			F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
18. Caseload Standards: *to increase the quality of our interventions and supports to children and their families.* Current standards remain – 100%.	**2006** **4Q – 100%**	LINK report	**A)** Continuous tracking and quality improvement process utilizing data reports on caseload standards (AO/CO).	Ongoing.
			B) Converted the existing durational social work positions into 25 permanent social work positions. Remaining 27 will stay as durational and filled by department as needed. An additional 9 durational staff will be added to staff.	Completed.
			C) Monitor social worker staffing levels through Human Resources, maintain a candidate pool and streamline hiring process for these positions.	Reports on vacancies and offers are ongoing. Live Scan for quicker background checks in operation, and changes were made to application to allow for background checks to begin prior to hiring.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
19. Reduction in Residential: *to increase opportunities for children to be in more clinically appropriate and least restrictive settings for services, to allow them to be closer to their families and communities, and to increase family involvement.* Residential placements must not exceed 11% of the total number of children in out of home care.	**2006** **4Q – 11%**	LINK report	**A)** The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing in all area offices.
			B) The no unilateral eject/no unilateral reject process was initiated in early 2006 with the advent of the Administrative Service Organization as well as the revision of the entire referral process to out-of-home care. Some of the most critical aspects of this process include such things as: the requirement of the Comprehensive Global Assessment (CGA); matching youth to appropriate provider vacancies using the CGA and the provider submitted Admission Criteria Forms; discussion of the referral with the provider by the CPT Director to ensure match; pre-placement meetings with all requisite individuals at the provider site (instead of multiple interviews and referrals); and more aggressive attempts to salvage placements by ARG, Enhance Care Coordinators, Psychologists/Licensed Social Workers, etc. before a youth is disrupted.	Ongoing.
			C) Budget expanded Intensive In-Home to offer an array of services to families along a continuum that promotes reunification/permanency for children and expand intensive in-home services such as, IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care.	Budget approved (July 2006) for a 1.2 million expansion. (July 2007) – for additional 1.2 million.
			D) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those “stuck” in Emergency Departments.
			E) Group Home development is underway which will significantly expand the number of group homes in the state. This activity is proposed to be sustained through the initial emphasis on out of state children.	To date 37 group homes have been open. Budget Option to annualize cost and continue development was supported by legislature.
			F) Beginning in March 2005 and continuing to date, Behavioral Health Program Directors meet biweekly with state facility superintendents and staff from the Bureau of Behavioral Health, Medicine and Education to review discharge plans for youth “overstays” in the facilities, safe homes, shelters, and private hospitals; Managed Service Systems, co-chaired by Area Directors and Enhanced Care	Ongoing.
			G) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. Twelve service providers have been identified through competitive procurement and approved by the Commissioners Office. Two contracts have been fully executed, and three contractors are delivering ISP services. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
20. Discharge Measures: *to ensure life skills and work/educational credentials before transitioning out of DCF so that they may have success as independent members of their communities.* For 85% of adolescents. Must be documented in LINK, i.e. Diplomas, College, GED, Employment or Military.	**2006** **4Q – 100%**	Case Review	**A)** Repositioned Adolescent Services within Department to bring greater focus to the needs of this target population and will enhance services and program support for independent living. **1.** Life skills training expansion. **2.** The Department in conjunction with the Department's of Social Services, Mental Health and Addictive Services, Economic Development, Office of Policy and Management and Connecticut Home Finance Authority will establish a Supportive Housing pilot for young adults transitioning from homelessness or youth systems (e.g. foster care or residential facilities).	The DCF continues to offer Train the User and Train the Trainer training around the Ansell-Casey Life Skills Program to DCF staff, Community Providers including residential, group home, SWETP and CHAP staff, Community Life Skills providers and Staff from the Connecticut DMHAS Youth Adults Program. To date 40 people have been trained as "Users" (only uses the program) and 10 people as "Trainers" (trains the program and is also a user) with another group receiving user training this November 2006. The DCF along with CHFA and a number of other State agencies have awarded contracts for Supportive Housing to 7 community providers for fiscal year 2006. RFP's for additional slots will be offered over the next 5-9 months.
			B) Develop alternative approaches aimed at doing outreach in the community (e.g. employers, support services, mentors, special training for foster/adoptive parents). Establish pilot with CT. Voices for Children in Hartford (40 slots) and Bridgeport (35 slots) (CT. Jim Casey Youth Opportunities Initiative) that serves to help youth transition successful from the foster care system.	The DCF continues to work with 75 youth in Bridgeport and Hartford around the Jim Casey Project and the Work to Learn Model. In addition, the Department has recently 11/1/06 awarded a contract to Marrakesh Inc. to provide a Work to Learn program, modeled after the Casey Project, for 60 New Haven area youth. This model is highlighted by the collaboration of many public agencies including Ct. Dept. of Labor, Governor's Prevention Partnership, State Board of Education, Ct. Court Supports Services Division and the New Haven Board of Education. The program is available for youth ages 14 to 21 involved with the DCF. An additional 20 slots have been purchased by CSSD for 16 and 17 year old youth involved in the adult court system's probation department.
			C) Work with Adolescent Units to resurrect adolescent advisory boards utilizing a regional format.	Ongoing.
			D) Implement pilot program at High Meadows with an emphasis on job coaching and job training to help with transition.	Implemented December 1, 2005 with 8 youth participating.
			E) TLAP Expansion - budget doubled from 3 to 6 the number of TLAP programs.	Expansion targeted for February 2007.
			F) Develop system to identify Adolescents (18+ years) that are in ILP/CHAPS program for reporting purposes.	Completed LINK enhancement.

Outcome Measure/ Performance Standard	Fourth Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
21. Discharge of Mentally Ill or Mentally Retarded Children: *to ensure the continuity of services for those transitioning out of DCF, to increase their ability to live with or near their families, and to have success in life.* 100% of referrals need to be made to DMHAS and DMR.	**2006** **4Q – 97%**	Case Review	**A)** Provide clarification for Interagency Coordination Policy (42-20-35) and referral of children under the age of 16 to social work staff.	In final stages of review.
			B) Distribute DMR and DMHAS policies, eligibility criteria, and referral process to all area office staff and provide with a regional contact from each agency for each of our area offices.	Ongoing. Developed an ongoing early identification process for youth at age 15 which is tracked through Central Office database.
			C) Developed new methodology to collect information for Outcome Measure 21. The new process is based on the need for timely identification of youth with either major mental illnesses or developmental disabilities, who need to be referred to either DMHAS or DMR for ongoing services at the time of transition from DCF. This methodology includes a protocol for: ▪ Use of standardized Department-wide clinical criteria to determine if referrals are needed and, ▪ The timely completion of referrals prior to age-out and/or transition, to assure adequate time for transition activities from the child to the adult agency.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Reallocated funds to DMR to develop programs for voluntary services clients with MR.	Completed.
22. Multi-Disciplinary Exams: *to assure early identification and intervention for medical/dental/behavioral needs and therefore the overall well being of children in our care.* 85% of children entering custody must have an MDE within 30 days.	**2006** **4Q – 94.2%**	ROM report	**A)** Expanded new diagnostic facilities from 5 to 14 sites statewide for children and enhance uniformity of service and quality of assessments.	Completed.
			B) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			C) Develop Social Work Supervisor Guide clarifying documentation and exception criteria.	Completed and posted online.

Juan F. v. Rell Exit Plan
Quarterly Report
October 1, 2006 – December 31, 2006
Civil Action No. H-89-859 (AHN)
March 29, 2007

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Juan F. v Rell Exit Plan Quarterly Report
October 1, 2006 – December 31, 2006

Highlights

1. On November 29, 2005 the Plaintiffs in the *Juan F.* case asserted non-compliance with provisions of the Revised Exit Plan of July 1, 2004. The cited provisions were: Treatment Plans (Outcome Measure 3), Children's Needs Met (Outcome Measure 15) and Multi-Disciplinary Exams (Outcome Measure 22). Negotiations began shortly thereafter, and a set of agreements have been reached since that time.

    - First, modifications were made to the methodology for conducting case reviews for Outcome Measures 3 and 15. The modifications included additional elements for review, which provide increased clarity to critical components of these reviews. In addition, these reviews now include a provision for reviewers' attendance at the Administrative Case Review/Treatment Planning Conference or Family Case Conference for each case reviewed. The Monitor's Office has utilized this methodology for the last two quarters.
    - Second, the parties agreed upon a set of monthly reports that provide point-in-time and longitudinal data. (See Appendix 1 for a copy of the March 21, 2007 Point-in-Time report).
    - Third, the parties agreed to an action plan for addressing key components of case practice related to meeting children's needs. The Action Plan focuses on heightened attention to permanency, placement and treatment issues including children in SAFE Homes and other emergency or temporary placements for more than 60 days; children in congregate care, especially children age 12 and under; and the permanency service needs of children in care, particularly those in care for 15 months or longer. The plan details action steps, strategies and implementation time-frames. (See Appendix 2 for a copy of the Plaintiff letter dated March 21, 2007, withdrawing the assertion of non-compliance and Appendix 3 for a copy of the *Juan F.* Action Plan). A monitoring plan is being developed that will integrate the current monitoring activities for the Exit Plan and additional monitoring activities necessary to track the implementation of the *Juan F.* Action Plan. Additional information, including baseline and current data are contained later in the report beginning on page seven (*Juan F.* Action Plan).

    The parties are to be commended for their dedicated and collaborative work in reaching agreement on important issues that impact children and families. The implementation of these agreements will benefit Connecticut's most vulnerable children and families.

2. The Monitor's quarterly review of the Department's efforts toward meeting the Exit Plan measures during the period of October 1, 2006 – December 31, 2006 indicates that the Department achieved 16 of the 22 measures. For the first time, the Department has met all three permanency goals Adoption (Outcome Measure 8), Transfer of Guardianship (Outcome Measure 9) and Reunification (Outcome Measure 7) during one quarter.

3. The revised methodology to measure Treatment Planning (Outcome Measure 3) and Needs Met (Outcome Measure 15) was utilized for a full sample of 73 cases during the fourth quarter. The fourth quarter case review data indicates that the Department achieved 41.1% appropriate Treatment Plans (Outcome Measure 3) and 52.1% on Children's Needs Met (Outcome Measure 15). The review indicates that additional work is required to assure that children, families, and relative and non-relative caregivers are engaged as full partners in a team approach. Families should be full participants in the decision-making process.

   Improvements in specifying clear, concise action steps for all case participants and identifying short-term goals and objectives are needed to enable the treatment plan to be utilized as the guiding document or "road map" for intervention and collaboration.

   The Department continues to struggle to meet the treatment and placement needs of a significant portion of the children and families it serves. Despite the increased resources that have been implemented as a result of the advocacy of the Department and support of the Governor and Legislature, wait-lists for mental health treatment, substance abuse treatment, and in-home services are common. Timely and appropriate treatment and placement alternatives are lacking. Additional foster and adoptive homes are needed to ensure that when appropriate, every child that requires out-of-home placement is matched and placed in a family-type setting. In addition, lapses in dental care and educational needs are noted in the review. The full report on the fourth quarter findings are contained later in this report beginning on page 10 (Monitor's Office Case Review for Outcome Measure 3 and Outcome Measure 15).

4. The Monitor's quarterly review of the Department for the period of October through December 2006; indicates that the Department has achieved compliance with a total of 16 measures.
   - Commencement of Investigations (95.5%)
   - Completion of Investigations (93.7%)
   - Search for Relatives (91.4%)
   - Maltreatment of Children in Out-of-Home Care (0.2%)
   - Reunification (61.3%)
   - Adoption (33.6%)
   - Timely Transfer of Guardianship (76.4%)
   - Multiple Placements (95%)
   - Foster Parent Training (100%)
   - Placement within License Capacity (96.4%)

- Worker to Child Visitation in Out-of-Home Cases (94.7%)
- Worker to Child Visitation in In-Home Cases (89.2%)
- Caseload Standards (100%)
- Reduction in Residential Care (11%)
- Discharge Measures (100%)
- Multi-disciplinary Exams (94.2%)

5. The Department has maintained compliance for at least two (2) consecutive quarters[1] with 15 of the Outcome Measures shown above (number of consecutive quarters indicated below):
    - Commencement of Investigations (ninth consecutive quarter)
    - Completion of Investigations (ninth consecutive quarter)
    - Search for Relatives (fifth consecutive quarter)
    - Maltreatment of Children in Out-of-Home Care (twelfth consecutive quarter)
    - Reunification (sixth consecutive quarter)
    - Transfer of Guardianship (second consecutive quarter)
    - Multiple Placements (eleventh consecutive quarter)
    - Foster Parent Training (eleventh consecutive quarter)
    - Placement within Licensed Capacity (second consecutive quarter)
    - Worker to Child Visitation in Out-of-Home Care (fourth consecutive quarter)
    - Worker to Child Visitation in In-Home Care (fifth consecutive quarter)
    - Caseloads Standards (eleventh consecutive quarter)
    - Residential Reduction (third consecutive quarter)
    - Discharge Measures (second consecutive quarter)
    - Multi-Disciplinary Exams (fourth consecutive quarter)

6. The Monitor's quarterly review of the Department for the period of October through December 2006 indicates that the Department did not achieve compliance with six (6) of the measures:
    - Treatment Plans (41.1%)
    - Repeat Maltreatment (7.9%)
    - Sibling Placement (85.5%)
    - Re-Entry (8.2%)
    - Children's Needs Met (52.1 %)
    - Discharge to DMHAS (97.0%)[2]

[1] The Defendants must be in compliance with all of the outcome measures, and in sustained compliance with all of the outcome measures for at least two consecutive quarters (six-months) prior to asserting compliance and shall maintain compliance through any decision to terminate jurisdiction.
[2] Discharge to DMHAS and DMR (Outcome Measure 21) is a 100% measure. One child did not have the required discharge plan. The plan for this child has since been completed and forwarded.

7. Beginning with the fourth quarter report, the Results Oriented Management (ROM) reporting system was utilized as the basis for Outcome Measures 1, 2, 4, 5, 7, 8, 9, 10, 11, 16, 17, 22. LINK reporting is used for Outcome Measures 6, 12, 14, 18, 19 and case reviews are required to report on Outcome Measures 3, 13, 15, 20, 21. Enhanced utilization of the ROM reporting system allows staff a real-time view of their case practice and Exit Plan achievements.

8. A joint program review report conducted by the DCF Court Monitor, the Office of the Child Advocate and the Department's Quality Improvement Division was disseminated to the public in December 2006. The Department is finalizing a work plan to address the recommendations in the report. Ongoing Court Monitor activities include review and monitoring of the Riverview Hospital Strategic Plan, updates with Department staff, facility visits, analysis of data, attendance at Advisory Board Meetings, and meetings with the union membership.

9. The Monitor's Office is conducting a Targeted Comprehensive Case Review of the Exit Plan Outcome Measures. This effort encompasses a review of multiple samples totaling approximately 2,000 cases. The review is being directed by the Court Monitor's Office and follows the methodology employed for all Court Monitor reviews which integrates Quality Improvement staff from the Department with staff contracted by the Court Monitor to conduct the work. The full report on this quantitative and qualitative review is expected to be completed in May 2007.

The Department's full, unedited, but verified report to the Court Monitor is incorporated at the end of this Monitor's Report to the Court (See Appendix 4).

4Q October 1-December 31, 2006 Exit Plan Report Outcome Measure Overview														
Measure	Measure	Base line	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005	1Q 2006	2Q 2006	3Q 2006	4Q 2006
1: **Investigation Commencement**	>=90%	X	X	X	X	91.2%	92.5%	95.1%	96.2%	96.1%	96.2%	96.4%	98.7%	95.5%
2: **Investigation Completion**	>=85%	73.7%	64.2%	68.8%	83.5%	91.7%	92.3%	92.3%	93.1%	94.2%	94.2%	93.1%	94.2%	93.7%
3: **Treatment Plans****	>=90%	X	X	X	10%	17%	X	X	X	X	X	X	54%	41%
4: **Search for Relatives***	>=85%	58%	93%	82%	44.6%	49.2%	65.1%	89.6%	89.9%	93.9%	93.1%	91.4%	5/15/07 *	8/15/07*
5: **Repeat Maltreatment**	<=7%	9.3%	9.4%	8.9%	9.4%	8.9%	8.2%	8.5%	9.1%	7.3%	6.3%	7.0%	7.9%	7.9%
6: **Maltreatment OOH Care**	<=2%	1.2%	0.5%	0.8%	0.9%	0.6%	0.8%	0.7%	0.8%	0.6%	0.4%	0.7%	0.7%	0.2%
7: **Reunification***	>=60%	57.8%	X	X	X	X	X	X	64.2%	61%	66.4%	64.4%	62.5%	61.3%
8: **Adoption**	>=32%	12.5%	10.7%	11.1%	29.6%	16.7%	33%	25.2%	34.4%	30.7%	40.8%	36.9%	27%	33.6%
9: **Transfer of Guardianship**	>=70%	60.5%	62.8%	52.4%	64.6%	63.3%	64.0%	72.8%	64.3%	72.4%	60.7%	63.1%	70.2%	76.4%
10: **Sibling Placement***	>=95%	57%	65%	53%	X	X	X	X	96%	94%	75%	77%	83%	85.5%
11: **Re-Entry**	<=7%	6.9%	X	X	X	X	X	X	7.2%	7.6%	6.7%	7.5%	4.3%	8.2%
12: **Multiple Placements**	>=85%	X	X	95.8%	95.2%	95.5%	96.2%	95.7%	95.8%	96%	96.2%	96.6%	96.8%	95%
13: **Foster Parent Training**	100%	X	X	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
14: **Placement Within Licensed Capacity**	>=96%	94.9%	88.3%	92.0%	93.0%	95.7%	97%	95.9%	94.8%	96.2%	95.2%	94.5%	96.7%	96.4%
15: **Needs Met****	>=80%	X	53%	57%	53%	56%	X	X	X	X	X	X	62%	52%
16: **Worker-Child Visitation (OOH)***	>=85% 100%	Monthly Quarterly	72% 87%	86% 98%	73% 93%	81% 91%	77.9% 93.3%	86.7% 95.7%	83.3% 92.8%	85.6% 91.9%	86.8% 93.1%	86.5% 90.9%	92.5% 91.5%	94.7% 99.0%
17: **Worker-Child Visitation (IH)***	>=85%	X	39%	40%	46%	33%	X	81.9%	78.3%	85.6%	86.2%	87.6%	85.7%	89.2%
18: **Caseload Standards+**	100%	69.2%	73.1%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%	100%
19: **Residential Reduction**	<=11%	13.5%	13.9%	14.3%	14.7%	13.9%	13.7%	12.6%	11.8%	11.6%	11.3%	10.8%	10.9%	11%
20: **Discharge Measures**	>=85%	61%	74%	52%	93%	83%	X	X	96%	92%	85%	91%	100%	100%
21: **Discharge to DMHAS and DMR**	100%	X	43%	64%	56%	60%	X	X	78%	70%	95%	97%	100%	97%
22: **MDE**	>=85%	5.6%	19.0%	24.5%	48.9%	44.7%	55.4%	52.1%	54.6%	72.1%	91.1%	89.9%	86%	94.2%

***Juan F.* Action Plan**

On November 29, 2005 the Plaintiffs in the *Juan F.* case asserted non-compliance with provisions of the Revised Exit Plan of July 1, 2004. The cited provisions were: Treatment Plans (Outcome Measure 3), Children's Needs Met (Outcome Measure 15) and Multi-Disciplinary Exams (Outcome Measure 22). Negotiations began shortly thereafter, and a set of agreements have been reached since that time.

- First, modifications were made to the methodology for conducting case reviews for Outcome Measures 3 and 15. The modifications included additional elements for review, which provide increased clarity to critical components of these reviews. In addition, these reviews now include a provision for reviewers' attendance at the Administrative Case Review/Treatment Planning Conference or Family Case Conference for each case reviewed. The Monitor's Office has utilized this methodology for the last two quarters.
- Second, the parties agreed upon a set of monthly reports that provide point-in-time and longitudinal data.
- Third, the parties agreed to an action plan for addressing key components of case practice related to meeting children's needs. The *Juan F*. Action Plan focuses on heightened attention to permanency, placement and treatment issues including children in SAFE Homes and other emergency or temporary placements for more than 60 days; children in congregate care, especially children age 12 and under; and the permanency service needs of children in care, particularly those in care for 15 months or longer. The plan details action steps, strategies and implementation time frames. A monitoring plan is being developed that will integrate the current monitoring activities for the Exit Plan, and additional monitoring activities necessary to track the implementation of the *Juan F.* Action Plan.

During the course of the next month a monitoring plan will be drafted for review and comment by the *Juan F*. parties. The plan will incorporate monitoring to track implementation and progress with the *Juan F*. Action Plan and the current ongoing monitoring activities related to the Exit Plan. The current monitoring activities include: data analysis and reporting on the 22 Outcome Measures, conducting and reporting targeted comprehensive case reviews, monitoring and intervention with emerging issues, and regular or topic specific meetings with stake-holders such as youth and families, foster and adoptive parents, private providers, community advocates, advisory boards, Legislators, DCF staff, the Technical Advisory Committee and the lawyers representing the parties in the *Juan F*. case. The monitoring plan will include provisions for analysis and presentation of data extracted from the agreed upon monthly reports, provisions for monitoring the implementation of strategies and initiatives outlined in the *Juan F.* Action Plan and provisions for conducting targeted case reviews of specific issues such as the population of the children age 12 and under in congregate care and children with Another Planned Permanent Living Arrangement (APPLA) goal.

The following is a presentation of baseline and current data regarding some of the significant areas of concern that are addressed in the *Juan F.* Action Plan. Future quarterly reports will include both quantitative data (point-in-time and longitudinal) and qualitative updates on specific initiatives outlined in the recent agreement to provide further insight and explanation of the data points below.

Permanency Issue	**Nov 2006**	**March 2007**
Total number of children, pre-TPR, TPR not filed, > 15 months in care, no compelling reason	823	252

No Permanency Goal	**Nov 2006**	**March 2007**
Number of children, with no Permanency goal, pre-TPR, > 2 months in care	93	37
Number of children, with no Permanency goal, pre-TPR, > 6 months in care	29	12
Number of children, with no Permanency goal, pre-TPR, > 15 months in care	11	9
Number of children, with no Permanency goal, pre-TPR, TPR not filed, > 15 months in care, no compelling reason	9	5

Preferred Permanency Goals	**Nov**	**March**
Adoption	**2006**	**2007**
Total number of children with Adoption goal, pre-TPR and post-TPR	1199	1304
Number of children with Adoption goal, pre-TPR	646	685
Number of children with Adoption goal, TPR not filed, > 15 months in care	129	111
• Reason TPR not filed, compelling reason	16	23
• Reason TPR not filed, petitions in progress	44	56
• Reason TPR not filed , child is placed with a relative	8	13
• Reason TPR not filed, services needed not provided	2	6
• Reason TPR not filed, blank	59	13
Number of cases with Adoption goal post-TPR	553	619
• Number of children with Adoption goal, post-TPR, in care > 15 months	524	576
Number of children with Adoption goal, post-TPR, no barrier, > 3 months since TPR	62	88
Number of children with Adoption goal, post-TPR, with barrier, > 3 months since TPR	269	307
Number of children with Adoption goal, post-TPR, with blank barrier, > 3 months since TPR	75	62

Reunification	**Nov 2006**	**March 2007**
Total number of children with Reunification goal, pre-TPR and post-TPR	2185	2082
Number of children with Reunification goal, pre-TPR	2177	2075
• Number of children with Reunification goal, pre-TPR, > 15 months in care	450	413
• Number of children with Reunification goal, pre-TPR, > 36 months in care	71	78
Number of children with Reunification goal, post-TPR	8	7

Transfer of Guardianship (Subsidized and Non-Subsidized)	**Nov 2006**	**March 2007**
Total number of children with Transfer of Guardianship goal (subsidized and non-subsidized), pre-TPR and post TPR	342	330
Number of children with Transfer of Guardianship goal (subsidized and non-subsidized), pre-TPR	333	329
• Number of children with Transfer of Guardianship goal (subsidized and non-subsidized , pre-TPR, > 22 months	100	76
• Number of children with Transfer of Guardianship goal (subsidized and non-subsidized), pre-TPR , > 36 months	29	29
Number of children with Transfer of Guardianship goal (subsidized and non-subsidized), post-TPR	7	1

Non-Preferred Permanency Goals	**Nov 2006**	**March 2007**
APPLA: Foster Care Non-Relative		
Total number of children with APPLA: Foster Care Non-Relative goal	749	735
Number of children with APPLA: Foster Care Non-Relative goal, pre-TPR	546	541
• Number of children with APPLA: Foster Care Non-Relative goal, 12 years old and under, pre-TPR	94	84
Number of children with APPLA: Foster Care Non-Relative goal, post-TPR	203	194
• Number of children with APPLA: Foster Care Non-Relative goal, 12 years old and under, post-TPR	44	35

APPLA: Other	**Nov 2006**	**March 2007**
Total number of children with APPLA: other goal	858	691
Number of children with APPLA: other goal, pre-TPR	736	563
• Number of children with APPLA: other goal, 12 years old and under, pre-TPR	34	40
Number of children with APPLA: other goal, post-TPR	122	128
• Number of children with APPLA: other goal, 12 years old and under, post-TPR	14	13

Long Term Foster Care Relative:	**Nov 2006**	**March 2007**
Total number of children with Long Term Foster Care Relative goal	215	199
Number of children with Long Term Foster Care Relative goal, pre-TPR	200	185
• Number of children with Long Term Foster Care Relative goal, 12 years old and under, pre-TPR	37	30
Long Term Foster Care Relative goal, post-TPR	15	14
• Number of children with Long Term Foster Care Relative goal, 12 years old and under, post-TPR	6	5

Placement Issues	**Nov 2006**	**March 2007**
Total number of children 12 years old and under, in Congregate Care	343	336
• Number of children 12 years old and under, in DCF Facilities	21	20
• Number of children 12 years old and under, in Group Homes	54	50
• Number of children 12 years old and under, in Residential	92	80
• Number of children 12 years old and under, in SAFE Home	148	153
• Number of children 12 years old and under, in Permanency Diagnostic Center	17	18
• Number of children 12 years old and under in MH Shelter	11	15
Total number of children ages 13-17 in Congregate Placements	1039	988
Total number of children in Residential care	668	675
• Number of children in Residential care, > 12 months in Residential placement	214	215
• Number of children in Residential care, > 60 months in Residential placement	6	6
Total number of children in SAFE Home	163	179
• Number of children in SAFE Home, > 60 days	79	99
• Number of children in SAFE Home, > 6 months	16	25
Total number of children in STAR/Shelter Placement	65	78
• Number of children in STAR/Shelter Placement, > 60 days	35	35
• Number of children in STAR/Shelter Placement, > 6 months	4	10
Total number of children in Permanency Planning Diagnostic Center	20	18
• Total number of children in Permanency Planning Diagnostic Center, > 60 days	13	15
• Total number of children in Permanency Planning Diagnostic Center, > 6 months	7	8
Total number of children in MH Shelter	13	15
• Total number of children in MH Shelter, > 60 days	10	13
• Total number of children in MH Shelter, > 6 months	7	6

Foster/Adoption Recruitment and Retention	**Nov 2006**	**Feb 2007**
• Number of Inquires	113	170
• Number of Open Houses	34	31
• Number of families starting Pride/GAP training	51	55
• Number of families completing Pride/GAP training	68	20
• Number of applications filed	138	93
• Number of applications that were licensed	72	77
• Number of applications pending beyond time frames	140	175
• Number of licensed Foster Homes at end of month	1281	1248
• Number of licensed Adoptive Homes at end of month	388	354
• Number of licensed Special Studies at end of month	236	221
• Number of licensed Independents at end of month	131	105
• Number of licensed Relatives at end of month	690	592
• Number of homes overcapacity (not due to sibling placement)	21	30
Total DCF Foster Care Bed Capacity	2551	2581
Total number of Specialized Foster Care (non-DCF) Homes	838	884

Monitor's Office Case Review for Outcome Measure 3 and Outcome Measure 15

I. Background and Methodology:

The *Juan F.* v Rell Revised Exit Plan and subsequent stipulated agreement reached by the parties and court ordered on July 11, 2006 requires the Monitor's Office to conduct a series of quarterly case reviews to monitor Treatment Planning (Outcome Measure 3) and Needs Met (Outcome Measure 15). The implementation of this review began with a pilot sample of 35 cases during the third quarter 2006. During the fourth quarter, 2006 the Monitor's Office reviewed a total of 73 cases[3] and will continue to review at least 70 cases in every subsequent quarter per the agreement.

The 73 case sample was stratified based upon the distribution of area office caseload on September 1, 2006. The sample incorporates both in-home and out-of-home cases based on the overall statewide percentage reflected at the point that the universe was drawn for sampling.

Table 1: Fourth Quarter Sample Required Based on September 1, 2006 Caseload Universe

Area Office	Total Caseload	% of State Total	Sample	IH Sample	OOH Sample
Bridgeport	1,109	8.2%	6	2	4
Danbury	297	2.2%	2	1	1
Greater New Haven	961	7.1%	5	1	4
Hartford	1,820	13.4%	9	2	7
Manchester	1,263	9.3%	7	2	5
Meriden	605	4.5%	3	1	2
Middletown	396	2.9%	3	1	2
New Britain	1,467	10.8%	8	3	5
New Haven Metro	1,423	10.5%	7	2	5
Norwalk	230	1.7%	2	1	1
Norwich	1,158	8.6%	6	2	4
Stamford	301	2.2%	2	1	1
Torrington	406	3.0%	3	1	2
Waterbury	1,257	9.3%	6	2	4
Willimantic	849	6.3%	4	1	3
Grand Total	13,542	100.0%	73	23	50

The methodology continues to pair the Department's staff with Monitor's Review staff. Reviewers were assigned to different teams and office locations for the third and fourth quarters so that no office had the same team reviewing their cases.

[3] The Exit Plan required a total of 70 cases be reviewed. Due to rounding and ensuring that each area office had representation of both in-home and out of home case assignments, a total of 73 cases was required.

Each case was subjected to the following methodology (A case review typically requires seven to 12 hours to complete).

1. A review of the Case LINK Record documentation for each sample case concentrating on the most recent six months. This includes narratives, treatment planning documentation, investigation protocols, and the provider narratives for any foster care provider during the last six-month period.
2. Attendance/Observation at the Treatment Planning Conference (TPC)/Administrative Case Review (ACR) or Family Conference (FC)[4].
3. A subsequent review of the final approved plan is conducted fourteen to twenty days following the date identified within the TPC/ACR/FC schedule from which the sample was drawn. Each reviewer completes an individual assessment of the treatment plan and needs met outcome measures and fills out the scoring forms for each.
4. A final meeting with the assigned teammate is held to jointly arrive at the final scores for each section and overall scoring for OM3 and 15. Individual scoring and joint scoring forms are then submitted to the Monitor. (This step may change as determined appropriate by the DCF Court Monitor after evaluation of the process, feedback from review staff and fiscal/staffing considerations.)

Although the criterion for scoring requires consistency in definition and process to ensure validity, no two treatment plans will look alike. Each case has unique circumstances that must be factored into the decision making process. Each reviewer has been provided with direction to evaluate the facts of the case in relationship to the standards and considerations and have a solid basis for justifying the scoring.

In situations where agreement cannot be reached, the team requests that the supervisor become a third voice on those areas of concern. They present their opinions and findings and the supervisor determines the appropriate score to reflect the level of performance for the specific item(s) and assists them in the overall determination of compliance for OM3 and OM15. If the team indicates that there are areas that do not attain the "very good" or "optimal" level, yet the consensus is the overall score should be "an appropriate treatment plan" or "needs met" the team outlines their reasoning for such a determination and it is reviewed by the Court Monitor for approval of an override exception. These cases are also forwarded to the Technical Advisory Committee (TAC) for review. During the fourth quarter, there were 19 cases submitted for override consideration. Of the 19 cases, seven resulted in the approval of an override to allow one or the other measure to achieve a passing score. These cases can be identified in the overall scoring tables later in this document.

To address the areas of disparity identified in the third quarter pilot, a post review team meeting was held in October to address individual reviewer's and teams' issues related to the review process. A sample case was identified prior to the meeting for record review and the ACR was attended by all reviewers via teleconference.

[4] Attendance at the family conference is included where possible. In many cases, while there is a treatment plan due, there is not a family conference scheduled during the quarter we are reviewing. To compensate for this, the Monitoring of in-home cases includes hard copy documentation from any family conference held within the six-month period leading up to the treatment plan due date.

Each subcategory was analyzed as a group. Clarifications were provided, and a better understanding of some of the finer points of the process resulted from this group review process and debriefing. Additional training and group meetings will continue throughout the process, and may include minor revisions to the tool or instructions as needed.

Sample Demographics

As indicated earlier, the sample consisted of seventy-three cases distributed among the fifteen area offices. Sample cases are identified by Assignment Type. At the point of review, the data indicates that the majority of cases (71.4%) are children in care for child protective service reasons. A full description of the sample is provided below:

Table 2: Case Assignment Types with the Sample Set (n=73)

Assignment	Frequency	Percent
CPS In-Home Family	21	28.8%
CPS Child in Placement	46	63.0%
Voluntary Services In-Home Family	1	1.4%
Voluntary Services Child in Placement	4	5.5%
Associated Family to Child in Placement (CPS)[5]	1	1.4%
Total	73	100.1%[6]

Of the children in placement during the quarter, nine children (17.3%) had some involvement with the juvenile justice system during the quarter.

In establishing the reason for the most recent case open date identified, reviewers ascertain all substantiations or voluntary service needs identified at the point of most recent case opening. This was a multiple response question which allowed the reviewers to select more than one response as situations warranted. In total, 133 reasons were identified for the 73 case sample. The data indicates that physical neglect is the most frequent reason for a case opening in treatment, as 61.6% of the cases cited this as one of the factors for the case opening. This was followed by Parental Substance Abuse/Mental Health which was present in 31.5% of the cases reviewed, and Emotional Neglect, which was identified in 23.3% of the cases reviewed.

[5] One case selected as an in-home case had child come into care shortly after the family conference was held. This is reflected as a difference of 1 in some charts depending upon the time frame and focus of the question.
[6] Due to rounding.

Table 3: Reasons for DCF involvement at the point of most recent case open/reopen date

Reason(s) Cited	Number	Percent of Instances Identified (n=133)	Percent of Sample Cases with Identified Reason (n=73)
Physical Neglect	45	33.8%	61.6%
Substance Abuse/Mental Health (Parent)	23	17.3%	31.5%
Emotional Neglect	17	12.8%	23.3%
Child's TPR	11	8.3%	15.1%
Physical Abuse	10	7.5%	13.7%
Domestic Violence	7	5.3%	9.6%
Educational Neglect	7	5.3%	9.6%
Voluntary Services Request	7	5.3%	9.6%
Abandonment	4	3.0%	5.5%
Emotional Abuse/Maltreatment	1	0.8%	1.4%
Sexual Abuse	1	0.8%	1.4%
Total	133		

When asked to isolate the primary reason for case opening among those identified for each case; physical neglect was identified for 37% of the sample set.

Table 4: What is the primary reason cited for case opening/reopening?

Primary Reason	Frequency	Percent
Physical Neglect	27	37.0%
Substance Abuse	11	15.1%
Child's TPR	10	13.7%
Emotional Neglect	6	8.2%
Voluntary Services	6	8.2%
Physical Abuse	4	5.5%
Abandonment	3	4.1%
Domestic Violence	2	2.7%
Educational Neglect	2	2.7%
Mental health	1	1.4%
Sexual Abuse/Exploitation	1	1.4%
Total	73	100.0%

Permanency/case goals were identified for 70 of the 73 cases reviewed (95.9%). Of the 21 situations in which "Reunification" was the permanency goal, there was a required concurrent plan documented in 18 cases (85.7%). All three indicated as UTD in the table below are CPS children in placement cases. Of the six cases with the goal of "APPLA: Other", four identified "Specialized Care to Transition to DMHAS/DMR" and two identified "Independent Living".

Table 5: What is the child or family's stated permanency goal on the most recent approved treatment plan in place during the period?

Permanency Goal	Frequency	Percent
Reunification	21	28.8
In-Home Goals - Safety/Well Being Issues	21	28.8
Adoption	12	16.4
APPLA: Permanent Non-Relative Foster Care	7	9.6
APPLA: Other	6	8.2
UTD - plan incomplete, unapproved/missing for this period	3	4.1
Transfer of Guardianship	2	2.7
Long Term Foster Care with a licensed relative	1	1.4
Total	73	100.0

Children in placement had various lengths of stay at the point of our review. This ranged from less than one month, to greater than 24 months. The distribution of length of stays is provided below with an indication of whether TPR has been filed in relation to both the ASFA requirement and overall length of time in care. In 11 of the cases indicated below, TPR had been granted prior to our review. An additional two cases had TPR pending (filed). There was only one child exceeding the ASFA 15 of the last 22 month time-frame for which neither TPR had been filed nor a Compelling Reason had been identified. This 15 year-old committed child's goal was APPLA: Permanent Non-Relative Foster Care.

Crosstabulation 1: Has child's length of stay exceeded the 15 of the last 22 benchmark set by ASFA? (Identified by case type) * For child in placement, has TPR been filed?

		For child in placement, has TPR been filed?					Total
Has child's length of stay exceeded the 15 of the last 22 benchmark set by ASFA?		**yes**	**no**	**N/A – Compelling Reason in LINK**	**N/A - child's goal and length of time in care don't require TPR**	**N/A - In-Home Case (CPS or Voluntary Services)**	
CPS CIP	**yes**	0	1	15	1[7]	0	17
CPS CIP	**no**[8]	1	2	0	14	0	17
CIP with TPR filed/granted	**N/A**	13	0	0	0	0	13
Voluntary Svc CIP	**yes**	0	0	0	1	0	1
Voluntary Svc CIP	**no**	0	0	0	3	0	3
N/A - In-Home Case (CPS or Voluntary Svc)		0	0	0	0	22	22
Total		**14**	**3**	**15**	**19**	**22**	**73**

[7] This is a child with Transfer of Guardianship as goal at point of review – TOG occurred shortly after review was completed.
[8] Includes the one child in associated family case at point of review.

II. Monitor's Findings Regarding Outcome Measure 3 – Treatment Plans

Outcome Measure 3 requires that, *"in at least 90% of the cases, except probate, interstate and subsidy only cases, appropriate treatment plans shall be developed as set forth in the "DCF Court Monitor's 2006 Protocol for Outcome Measures 3 and 15" dated June 29, 2006 and the accompanying "Directional Guide for OM3 and OM15 Reviews" dated June 29, 2006."*

The fourth quarter case review data indicates that the Department attained the level of "Appropriate Treatment Plan" in 30 of the 73-case sample or **41.1%.**

The findings of this review indicate that the Department has not been successful in utilizing the treatment plans as the primary outline or "road map" for communicating, evaluating and targeting specific action steps to meet children's and families needs. Similarly, while there has been improvement in the degree of family engagement and family participation in the development of the treatment plans, the review confirms that many children and families are not actively incorporated or participating in the process. In spite of efforts by the ACR Social Work Supervisor to assist case practice through identification of issues within the course of the meetings, the treatment planning process often remains a "pro-forma" exercise as documented within reviewers' notes on the cases reviewed. This is demonstrated in many cases, as changes discussed at the TPC/ACR meetings are not reflected in the final approved treatment plan document.

No case failed solely as a result of the language or approval requirement. However, five of the plans not passing due to less than "very good" scores also did not have social work supervisory approval. Four cases had no plan less than 7 months old at the point of review as a result of the failure of the social work supervisor to approve the current plan reviewed for our sample. Seventy cases (95.9%) had documentation that families' language needs were met. In the three cases without documentation of translation, two were also in the pool of those not approved by a supervisor. The one remaining case without documentation of translation included sections scored less than "very good" and would not have passed had translation been documented.

The overall score designation is similar between the in-home and out of home cases in this quarter's sample. In nine of twenty two in-home cases (both CPS and Voluntary Services) the treatment plan passed the overall measure with a designation of appropriate treatment plan (40.9%). In 21 of 51 children in placement cases (41.2%), the treatment plan achieved the appropriate treatment plan status. See crosstabulation below.

Crosstabulation Table 2: What is the type of case assignment noted in LINK? * Overall Score for OM3

	Overall Score for OM3		
What is the type of case assignment noted in LINK?	**Appropriate Treatment Plan**	**Not an Appropriate Treatment Plan**	**Total**
CPS In-Home Family Case (IHF)	9	12	21
CPS Child in Placement Case (CIP)	20	26	46
Voluntary Services In-Home Family Case (VSIHF)	0	1	1
Voluntary Services Child in Placement Case (VSCIP)	1	3	4
Associated Voluntary Services Family Case (ACSCIPF)	0	1	1
Total	**30**	**43**	**73**

The review examined the level of engagement with children, families and providers in the development of the treatment plans as well as the content of the plan document itself. Each case had a unique pool of active participants for the Department to collaborate with in the process. The chart below indicates the degree to which identifiable/active case participants were engaged by the social worker and the extent to which active participants attended the TPC/ACR/FC. Percentages reflect the level or degree to which a valid participant was part of the treatment planning efforts across all the cases reviewed.

Table 6: Participation and Attendance Rates for Active Case Participants within the Sample Set

Identified Case Participant	Percentage with documented Participation/Engagement in Treatment Planning Discussion	Percentage Attending the TPC/ACR or Family Conference
Child	79.3%	21.4%
Mother	68.3%	51.8%
Father	47.2%	27.1%
Foster Parent	81.3%	61.3%
Active Service Providers	73.5%	35.1%
Attorney/GAL (Child)	26.9%	6.0%
Parents' Attorney	29.7%	17.1%
Other DCF Staff	58.7%	48.8%
Other Participants	71.7%	64.1%

It is clear from the attendance and engagement rates indicated above that the Department, while improving over time, still requires additional effort to engage and incorporate key participants. Reviewers noted a failure to invite adolescents and fathers, and the overall lack of engagement with both children's and parents' attorneys.

As with the third quarter, this review process looked at eight categories of measurement when determining overall appropriateness of the treatment planning (OM3). Scores were based upon the following rank/scale.

Optimal Score – 5
The reviewer finds evidence of all essential treatment planning efforts for both the standard of compliance and all relevant consideration items (documented on the treatment plan itself).

Very Good Score – 4
The reviewer finds evidence that essential elements for the standard of compliance are substantially present in the final treatment plan and may be further clarified or expanded on the DCF 553 (where latitude is allowed as specified below) given the review of relevant consideration items.

Marginal Score – 3
There is an attempt to include the essential elements for compliance but the review finds that substantial elements for compliance as detailed by the Department's protocol are not present. Some relevant considerations have not been incorporated into the process.

Poor Score – 2
The reviewer finds a failure to incorporate the most essential elements for the standard of compliance detailed in the Department's protocol. The process does not take into account the relevant considerations deemed essential, and the resulting document is in conflict with record review findings and observations during attendance at the ACR.

Absent/Adverse Score – 1
The reviewer finds no attempt to incorporate the standard for compliance or relevant considerations identified by the Department's protocol. As a result there is no treatment plan less than 7 months old at the point of review or the process has been so poorly performed that it has had an adverse affect on case planning efforts. "Reason for Involvement" and "Present Situation to Date" were most frequently ranked with an Optimal Score. Deficits were most frequently noted in two of the eight categories: "Determination of Goals/Objectives" and "Action Steps to Achieve Goals". The following table provides the scoring for each category for the sample set and the corresponding percentage of cases within the sample that achieved that ranking.

Overall there was no major discrepancy by case type. The set of three tables on page 11 provide at a glance, the scores for each of the eight categories of measurement within Outcome Measure 3. The first is the full sample, the second is the children in out of home placement (CIP) cases and the third is the in-home family cases. For a complete listing of rank scores for Outcome Measure 3 by case, see Appendix 5.

Table 7: Measurements of Treatment Plan OM 3 – Number and Percent of Rank Scores for All Cases Across All Categories of OM3

Category	Optimal "5"	Very Good "4"	Marginal "3"	Poor "2"	Adverse/Absent "1"
I.1 Reason for DCF Involvement	30 (41.1%)	34 (46.6%)	8 (11.0%)	1 (1.4%)	0 (0%)
I.2. Identifying Information	13 (17.8%)	41 (56.2%)	18 (24.7%)	1 (1.4%)	0 (0%)
I.3. Strengths/Needs/Other Issues	20 (27.4%)	38 (52.1%)	13 (17.8%)	2 (2.7%)	0 (0%)
I.4. Present Situation and Assessment to Date of Review	19 (26.0%)	34 (46.6%)	19 (26.0%)	1 (1.4%)	0 (0%)
II.1 Determining the Goals/Objectives	7 (9.6%)	29 (39.7%)	30 (41.1%)	6 (8.2%)	1 (1.4%)
II.2. Progress[9]	16 (21.9%)	34 (46.6%)	11 (15.1%)	4 (5.5%)	1 (1.4%)
II.3 Action Steps to Achieving Goals Identified	3 (4.1%)	34 (46.6%)	30 (41.1%)	4 (5.5%)	2 (2.7%)
II.4 Planning for Permanency	21 (28.8%)	39 (53.4%)	8 (11.0%)	5 (6.8%)	0 (0%)

Table 8: Measurements of Treatment Plan OM 3 – Number and Percent of Rank Scores for Out of Home (CIP) Cases Across All Categories of OM3

Category	Optimal "5"	Very Good "4"	Marginal "3"	Poor "2"	Adverse/Absent "1"
I.1 Reason for DCF Involvement	19 (38.0%)	25 (50.0%)	5 (10.0%)	1 (2.0%)	0 (0%)
I.2. Identifying Information	8 (16.0%)	28 (56.0%)	13 (26.0%)	1 (2.0%)	0 (0%)
I.3. Strengths/Needs/Other Issues	13 (26.0%)	26 (52.0%)	10 (20.0%)	1 (2.0%)	0 (0%)
I.4. Present Situation and Assessment to Date of Review	14 (28.0%)	23 (46.0%)	13 (26.0%)	0 (0%)	0 (0%)
II.1 Determining the Goals/Objectives	5 (10.0%)	20 (40.0%)	19 (38.0%)	5 (10.0%)	1 (2.0%)
II.2. Progress[10]	9 (18.0%)	26 (52.0%)	9 (18.0%)	2 (4.0%)	1 (2.0%)
II.3 Action Steps to Achieving Goals Identified	1 (2.0%)	25 (50.0%)	19 (38.0%)	3 (6.0%)	2 (4.0%)
II.4 Planning for Permanency	12 (24.0%)	27 (54.0%)	6 (12.0%)	5 (10.0%)	0 (0%)

Table 9: Measurements of Treatment Plan OM 3 – Number and Percent of Rank Scores for In-Home Family Cases Across All Categories of OM3

Category	Optimal "5"	Very Good "4"	Marginal "3"	Poor "2"	Adverse/Absent "1"
I.1 Reason for DCF Involvement	11 (47.8%)	9 (39.1%)	3 (13.0%)	0 (0%)	0 (0%)
I.2. Identifying Information	5 (21.7%)	13 (56.5%)	5 (21.7%)	0 (0%)	0 (0%)
I.3. Strengths/Needs/Other Issues	7 (30.4 %)	12 (52.2%)	3 (13.0%)	1 (4.3%)	0 (0%)
I.4. Present Situation and Assessment to Date of Review	5 (21.7%)	11 (47.8%)	6 (26.1%)	1 (4.3%)	0 (0%)
II.1 Determining the Goals/Objectives	2 (8.7%)	9 (39.1%)	11 (47.8%)	1 (4.3%)	0 (0%)
II.2. Progress[11]	7 (30.4%)	8 (34.8%)	2 (8.7%)	2 (8.7%)	0 (0%)
II.3 Action Steps to Achieving Goals Identified	2 (8.7%)	9 (39.1%)	11 (47.8%)	1 (4.3%)	0 (0%)
II.4 Planning for Permanency	9 (39.1%)	12 (52.2%)	2 (8.7%)	0 (0%)	0 (0%)

[9] Seven cases were newly opened – ranked as N/A- too early to note progress (2.9%).
[10] Three cases were newly opened – ranked as N/A-too early to note progress (6.0%).
[11] Four cases were newly opened – ranked as N/A-too early to note progress (6.0%).

It is clear from the tables provided regarding these eight categories of measurement that DCF continues to struggle with identifying the goals and objectives for the coming six-month period (II.1), and assignment of action steps for the case participants in relation to those goals (II.3). The highest percentage of "Marginal", "Poor" or "Adverse" scores were identified for Section II.1 with 50.7% of the cases not achieving a passing grade. It appears that there is still some confusion on the part of the social worker and social work supervisors regarding the distinction between permanency goals, and the short term goals and objectives section. Section II.3 did not pass in 49.3% of the cases. In many instances, the Department failed to incorporate its own responsibilities and action steps for the case over the next six months, minimized parent or provider responsibility, or did not provide clear measurement, time-frames, or identify responsible participants.

Additionally, the "Present Situation and Assessment to Date Section" (I.4) continues to be problematic to many of the area offices. In all, 27.4% of the plans failed to achieve a passing score in relation to this category as the treatment plan did not incorporate all available data or perspectives identified within LINK or at the ACR/TPC/FC meeting. The sample data indicates that 82.2% of the plans did identify an appropriate treatment plan permanency goal for the child or family, and the Department is becoming more adept at including appropriate identifying information for active case participants (74.0%).

IV. Monitor's Findings Regarding Outcome Measure 15 – Needs Met

Outcome Measure 15 requires that, *"at least 80% of all families and children shall have all their medical, dental, mental health and other service needs met as set forth in the "DCF Court Monitor's 2006 Protocol for Outcome Measures 3 and 15 dated June 29, 2006, and the accompanying 'Directional Guide for OM3 and OM15 Reviews dated June 29, 2006."*

The case review data indicates that the Department attained the designation of "Needs Met" in **52.1%** of the 73 case sample.

In addition to the identification of areas requiring improvement to better meet children's service needs, the review confirms that in many cases the Department fails to embrace the Treatment Planning process as a foundational means of working collaboratively with children, families and other stakeholders. As a result, many treatment plans don't reflect the input of the family and other stakeholders nor the comments, agreements, evaluation of progress and necessary revisions discussed at the ACR/TPC. This results in a lack of clarity for families and stakeholders regarding progress, expectations, action steps, and service needs and goals for the subsequent six-month period.

There is only a slight variation when looking at the case assignment type in relation to needs met. Of the 23 cases selected as in-home family cases, thirteen or 56.5% achieved "needs met" status. Twenty-five of the 50 cases with children in placement (both CPS and Voluntary) achieved "needs met" status (50.0%).

Crosstabulation 3: What is the type of case assignment noted in LINK? * Overall Score for Outcome Measure 15

What is the type of case assignment noted in LINK?	Overall Score for Outcome Measure 15		
	Needs Met	Needs Not Met	Total
CPS In-Home Family Case (IHF)	13	8	21
CPS Child in Placement Case (CIP)	23	23	46
Voluntary Services In-Home Family Case (VSIHF)	0	1	1
Voluntary Services Child in Placement Case (VSCIP)	2	2	4
Associated Voluntary Services Family Case (ACSCIPF)	0	1	1
Total	38	35	73

The overall score was also looked at through the filter of the stated permanency goal as shown below:

Crosstabulation 4: What is the child or family's stated goal on the most recent approved treatment plan in place during the period? * Overall Score for Outcome Measure 15

What is the child or family's stated goal on the most recent approved treatment plan in place during the period?	Overall Score for Outcome Measure 15		
	Needs Met	Needs Not Met	Total
Reunification	10	9	19
Adoption	7	5	12
Transfer of Guardianship	1	1	2
Long Term Foster Care with a licensed relative	0	1	1
APPLA: Permanent Non-Relative Foster Care	3	4	7
APPLA: Other	3	3	6
In-Home Goals - Safety/Well Being Issues	12	9	21
UTD - plan incomplete, unapproved/missing for this period	2	3	5
Total	**38**	**35**	**73**

In total, Outcome Measure 15 looked at twelve categories of measurement to determine the level with which the Department was able to meet the needs of families and children. When looking at a break between passing scores (5 or 4) and those not passing (3 or less) there is a marked difference in performance among the categories. It is clear that the Department has the most difficulty in meeting the dental needs of children. This was followed by issues identified for categories of "Safety: In-Home", "DCF Case Management/Contracting or Providing Services to Achieve the Permanency Goal,"

"Child's Current Placement", and "Mental Health, Behavioral Health, and Substance Abuse Services". DCF scored highest in providing prompt legal action (II.2), attending to medical needs (II.1), and recruitment efforts during the prior six (II.3) months. Of the thirteen cases identifying dental as an unmet need, the barrier was unable to be determined (UTD) for 46.2% (6 cases); was related to DCF case management in 38.5% (5 cases); and was identified as wait list or insurance in one case each or 7.7%. While one may make the assumption that the "UTD's" have to do with availability of service, and perhaps some of the delays in referrals may also be the result of the limited pool of providers, workers often do not document the barriers in the LINK record. A targeted study may be required to get an accurate view of this issue.

Table 10: Identification of Outcome Measure 3 categories and resulting percentage achieving/not achieving "passing" scores of 4 or 5

Category	# Passing (Scores 4 or 5)	# Not Passing (Scores 3 or Less)
DCF Case Management – **Legal Action** to Achieve the Permanency Goal During the Prior Six Months (II.2)	91.8%	8.2%
Medical Needs (III.1)	89.0%	11.0%
DCF Case Management – Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months (II.3)	85.5%	14.5%
Securing the Permanent Placement – Action Plan for the Next Six Months (II.1)	83.3%	16.7%
Safety – Children in Placement (I.2)	83.0%	17.0%
Educational Needs (IV. 2)	81.5%	18.5%
Mental Health, Behavioral and Substance Abuse Services (III.3)	81.2%	18.8%
Child's **Current Placement** (IV.1)	79.2%	20.8%
DCF Case Management – Contracting or Providing Services to achieve the Permanency Goal **during the Prior Six Months** (II.4)	72.5%	27.5%
Safety – In Home (I.1)	67.9%	32.1%
Dental Needs (III.2)	63.0%	37.0%

All categories are in Table 11 below with the frequency and percentage of applicable cases achieving each rank score below.

Table 11: Measurements of Treatment Plan OM 15 – Percentage of Rank Scores Attained Across All Categories[12]

Category	# Ranked Optimal "5"	# Ranked Very Good "4"	# Ranked Marginal "3"	# Ranked Poor "2"	# Ranked Adverse/Absent "1"	N/A To Case
I.1 Safety – In Home	3(10.7%)	16 (57.1%)	8 (28.6%)	1 (3.6%)	0 (0%)	45
I.2. Safety – Children in Placement	19 (35.8%)	25 (47.2%)	8 (15.1%)	0 (0%)	1 (1.9%)	20
II.1 Securing the Permanent Placement – Action Plan for the Next Six Months	22 (40.7%)	23 (42.6%)	8 (14.8%)	1 (1.9%)	0 (0%)	19
II.2. DCF Case Management – Legal Action to Achieve the Permanency Goal During the Prior Six Months	39 (53.4%)	28 (38.4%)	6 (8.2%)	0 (0%)	0 (0%)	0
II.3 DCF Case Management – Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months	32 (58.2%)	15 (27.3%)	7 (12.7%)	1 (1.8%)	0 (0%)	18
II.4. DCF Case Management – Contracting or Providing Services to achieve the Permanency Goal during the Prior Six Months	25 (36.2%)	25 (36.2%)	15 (21.7%)	4 (5.8%)	0 (0%)	4
III.1 Medical Needs	33 (45.2%)	32 (43.8%)	7 (9.6%)	1 (1.4%)	0 (0%)	0
III.2 Dental Needs	34 (46.6%)	12 (16.4%)	19 (26.0%)	4 (5.5%)	4 (5.5%)	0
III.3 Mental Health, Behavioral and Substance Abuse Services	21 (30.4%)	35 (50.7%)	10 (14.5%)	3 (4.3%)	0 (0%)	4
IV.1 Child's Current Placement	28 (52.8%)	14 (26.4%)	10 (18.9%)	1 (1.9%)	0 (0%)	20
IV. 2 Educational Needs	29 (44.6%)	24 (36.9%)	12 (18.5%)	0 (0%)	0 (0%)	8

For a complete listing of rank scores for Outcome Measure 15 by case, see Appendix 5.

[12] Percentages are based on applicable cases for the individual measure. Those cases marked N/A are excluded from the denominator in each row's calculation of percentage. At the point of sampling, the total number identified for the in-home sample was 23 cases. However, a number of cases had both in-home and out of home status at some point during the six-month period of review.

In addition to looking at the twelve categories of Outcome Measure 15, the review collected data on situations in which a case had a need identified at the prior ACR, in the prior treatment plan or within the six-month period of LINK record reviewed. Data was collected on those needs that remained unresolved at the point of the most recent treatment planning efforts. In 34 of the 73 cases, the reviewers found no needs from the six-month period of review that remained unmet at the point of scoring post ACR. Also noted were several situations in which the needs were met but not in a timely manner, which reduced the scoring to less than a "4". These needs, through not met in a timely manner, would not be captured as unmet per the definitions of the tool. Examples of this would be a child that was in an inappropriate placement for a portion of the review period due to delay in referral, but by the end of the six months was correctly matched to the appropriate level of care, or a parent refusing substance abuse screens up through the end of the treatment planning cycle with no intervention by ARG or legal action to stimulate participation.

A total of 34 cases had no unmet needs identified. In the remaining 39 cases, a total of 84 needs were identified by reviewers, where the action or service was still remaining or necessary at the point of the review. Of those identified needs remaining unmet at the end of the prior treatment planning cycle, "mental health treatment" was the most frequently cited, (23.3% of the cases). Others included in the data collection are listed below:

Table 12: Unmet Service Needs Identified within the Sample Set Cases

Identified Category of Service Need Type	Frequency	% of cases
No Unmet Needs Identified	34	46.6%
Mental Health Treatment	17	23.3%
Substance Abuse Treatment	14	19.2%
Dental Care	13	17.8%
In-Home Support Services	11	15.1%
Out of Home Placement	9	12.3%
Educational Need	7	9.6%
Out of Home Support Services	4	5.5%
DCF Case Management	4	5.5%
Medical Care	3	4.1%
Domestic Violence Services	2	2.7%
Total	**118**	

Additionally barriers were identified for the 84 unmet needs cited above. Most frequently the barrier was identified as delay in referral by worker (23.8%), followed closely by client refusal (20.2%). Anecdotally, although client refusal was cited by the worker as the reason for unmet needs at the ACR or within the LINK record, reviewers often commented in their notes that ARG assistance or collaboration with providers was often not pursued to engage parents. All barriers identified are found in table 13 below:

Table 13: Barriers for Identified Unmet Service Needs

Barrier	Frequency	% of Overall Barriers Identified
Delay in referral by worker	20	23.8%
Client refused service	17	20.2%
UTD from treatment plan or narrative	16	19.0%
Other *	6	7.1%
Placed on waiting list	6	7.1%
Referred service is unwilling to engage client	4	4.8%
Service does not exist in the community	3	3.6%
Insurance issues	3	3.6%
No slots available	3	3.6%
Approval process	2	2.4%
No service identified	1	1.2%
Service not available for age group	1	1.2%
Service deferred pending completion of another	1	1.2%
Financing unavailable	1	1.2%
	84	

** Included: scheduling issues (3), poor communication (2), Provider did not follow through (1)*

In addition, when looking specifically at the most recent treatment planning document, 23 cases (31.5%) had a service need that was clearly identified at the ACR/TPC or within LINK documentation that was not incorporated into the treatment plan document. This included a total of 97 service needs. The most frequently noted need is a mental health service. It is important to note that while there were 97 needs that may not have been incorporated into the treatment planning document, in many cases, the ACR/TPC/FC discussions adequately addressed case work, and or the responsibility of participants toward meeting the need.

Table 14: Service Needs Not Incorporated into the Current Treatment Plan

Identified Category of Service Need Type	Frequency	% of Needs
All identified needs incorporated into Treatment Plan	50	51.5%
Mental health	12	12.4%
Education	8	8.2%
Dental	6	6.2%
DCF case management	5	5.2%
Medical care	4	4.1%
Out of home support services	3	3.1%
Domestic violence treatment	2	2.1%
Substance abuse treatment	2	2.1%
Training	2	2.1%
Out of home placement	2	2.1%
In-home support services	1	1.0%
	97	