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Quality Assurance Processes in Maryland Child Welfare

4th Annual Child Welfare Accountability Report

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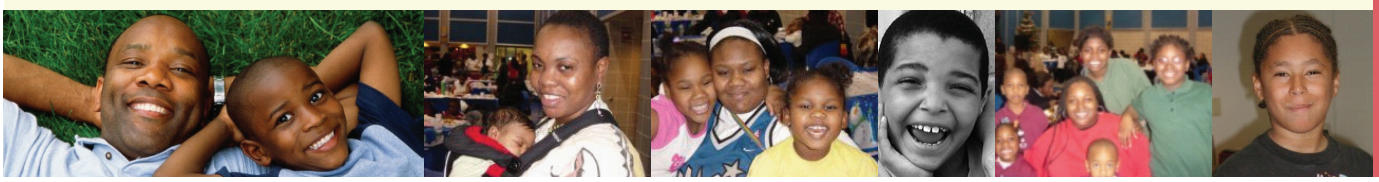

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Terry V. Shaw, Nina Esaki, Haksoon Ahn, and Diane DePanfilis co-managed the interagency agreement for the Quality Assurance process. Gillian Gregory and Julia O'Connor led the Local Supervisory Review process and Foster Parent Survey. Heidi Melz oversaw the Family Centered Practice evaluation component.

Carnitra White, Richard Larson, David Ayer and Linda Carter at DHR/SSA guided the activities related to the Quality Assurance process.

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Executive Summary

The Child Welfare Accountability Act of 2006 (Maryland Family Law, Section 1301 through 1311 inclusive) specified the development and implementation of a process to measure the efficiency and effectiveness of child welfare services in Maryland that addresses the safety, permanency and well-being of children in the care and custody the Maryland Department of Human Resources/the Local Departments of Social Services. The Quality Assurance Process in Maryland Child Welfare does this through the evaluation of quality assurance and system implementation processes in Maryland's child welfare system. The state of Maryland made great strides in 2010 towards achieving of the development of an integrated, comprehensive Quality Assurance system.

Highlighted Accomplishments in 2010

- DHR/SSA in partnership with UMB/SSW designed and implemented a Quality Assurance Process based on a combination of cutting edge research related to improving child welfare outcomes, improved data analysis capabilities through MD CHESSIE, and the collective experience of staff at DHR/SSA (see Overview of the Maryland Quality Assurance System).

- DHR/SSA in collaboration with the RYC implemented an enhanced Local Supervisory Review Instruments (LSRI) process that incorporated two new program assignment modules as well as additional items designed to assess the quality of casework practice around Family Centered Practice (FCP; see Local Supervisory Review Instruments).

- RYC in collaboration with DHR/SSA enhanced the ongoing Foster Parent Survey mechanism. The enhanced survey will be used to solicit feedback on Maryland foster parents' perceptions of the training and supports available through DHR/SSA (see Maryland Foster Parent Survey).

- RYC implemented a comprehensive evaluation plan for Maryland's Family Centered Practice model of service delivery (see Evaluating Family Centered Practice in Maryland).

Priorities in 2011

In the past three years, Maryland's Quality Assurance system has continued to make progress and can now critically examine issues pertaining to the quality of child welfare practice. Improvements in the quality of state-wide data in the MD

CHESSIE system, the availability of information through the Local Supervisory Review Instrument, and improved processes for case reviews all lead to an ability to effectively drive policy and programmatic decisions.

Other components ongoing implementation of the Foster Parent Survey.. The following priority areas should be targeted in 2011 and FY2012:

- Continue full implementation of the newly designed Continuous Quality Improvement process (see Overview of the Maryland Quality Assurance System).

- Conduct validity and reliability studies on the revised Local Supervisory Review Instrument to test the soundness of the instrument (see Next Steps: Local Supervisory Review Instrument).

- Continue the Foster Parent Survey and make enhancements to the survey to provide new information that may help inform DHR/SSA changes in foster parent recruitment and retention policies and practices (see Next Steps: Foster Parent Survey).

- Initiate a follow-up evaluation of Family Centered Practice (FCP) building upon the first evaluation and using a longitudinal study design to better assess the impact of FCP on children and families (see Next Steps: Evaluation Family Centered Practice in Maryland).

- Continue to monitor the completeness of data elements related to safety and risk assessments (see Next Steps: Data Driven Caseload Calculation).

- Continue to build the capacity of local departments to be sophisticated users of data to inform program development.

Introduction

The Child Welfare Accountability Act of 2006 increased legislative oversight of the Maryland Quality Assurance processes in child welfare and provided a framework for the Department of Human Resources, Social Services Administration (DHR/SSA) to partner with the University of Maryland Baltimore, School of Social Work (UMB/SSW) Ruth H. Young Center for Families and Children (RYC) to develop and refine the Maryland Child Welfare Quality Assurance (QA) process.

The purpose of the Quality Assurance unit within DHR/SSA is to evaluate the Maryland child welfare system and make recommendations for improvement. During the 2010 calendar year, RYC research staff provided technical assistance to DHR/SSA staff in revising the QA process.

This report presents the results of the Quality Assurance initiatives for calendar year 2010. It was written by faculty and staff at RYC and reviewed by administrators at DHR for presentation to the Maryland State Legislature.

A separate companion report, *Maryland Child Welfare Performance Indicators: 4th Annual Child Welfare Accountability Report,* describes Maryland's performance on the outcome and performance measures outlined by the Child Welfare Accountability Act.

Overview of the Maryland Quality Assurance System

The majority of calendar year 2010 was devoted to implementing a revised Continuous Quality Improvement (CQI) Process for Maryland. The revised CQI process was designed based on current research and best practices in child welfare evaluation and quality improvement, as well as feedback from the LDSSs, Results Accountability, strategies identified by DHR/SSA to improve efficiency and prior recommendations from the QA Collaborative. RYC assisted in providing consultation regarding current research study. A pilot Quality Assurance/Continuous Quality Improvement (CQI) process manual was designed and distributed to local jurisdictions for review and feedback in early 2010.

In calendar year 2009, DHR/SSA had reorganized the QA unit to streamline the quality assurance process and better address the QA needs

of local jurisdictions. The Local Department of Social Services (LDSS) Child Welfare Continuous Quality Improvement (CQI) Process created by DHR/SSA is designed to improve outcomes for children and families served by the Maryland child welfare system, utilizing a collaborative DHR/LDSS partnership to evaluate current outcomes, assess areas of strengths, identify areas needing improvement, and develop and monitor LDSS plans to improve outcomes for children and families.

The major components of the CQI Process are the Quality Assessment Review (QAR), the Targeted QA Review, and the Continuous Quality Improvement Plan (CQI Plan). The LDSS develops the QAR through a process of self-assessment, data analysis, and local stakeholder focus groups. The Targeted QA Review includes intensive case reviews during an on-site review which is based on the QAR and led by DHR/SSA QA staff. The CQI Plan is developed by the LDSS in consultation with DHR/SSA and is based on the QAR and the Targeted QA Review, including strategies to improve child welfare outcomes. The CQI Plan is designed to be implemented and tracked over a three year period, with measurements of key targets monitored on a semi-annual basis.

The new CQI system provides a structure for:

- careful evaluation of each department's strengths and areas needing improvement,
- in-depth reviews of specific cases to assess quality of services provided,
- integration of the perspectives of internal and external stakeholders, and
- data-driven needs and strengths assessments that are used for ongoing program improvement.

The QA process in Maryland continues to advance, building upon QA activities and experiences over the past three years. In particular the increasing use of MD CHESSIE data to analyze and track trends on key performance indicators within LDSSs and across the state. In 2010, Quality Assessment Reviews and Targeted On-Site Reviews were completed for Somerset and Worcester LDSSs. Both LDSSs will develop and initiate their Continuous Improvement Plans during calendar year 2011. Meanwhile, DHR/SSA will continue the CQI process with all LDSSs.

Maryland's revised CQI process has been reviewed by state, local, and federal partners. At the federal level, the new CQI policies and procedures have been reviewed by staff at the Department of Health and Human

Services/ Administration for Children and Families/ Children's Bureau, who were impressed with this new system and felt that it represented significant opportunities to provide meaningful data and feedback to both local and state leaders.

Local Supervisory Review Instrument

DHR/SSA developed the Local Supervisory Review Instrument (LSRI) to provide supervisors a standardized tool to assess caseworker's quality of practice toward achieving child welfare outcomes of safety, permanency, and well-being. The original instrument was implemented in January 2007 and was then quickly revised based on stakeholder feedback to reflect a stronger emphasis on quality of practice. The new instrument was piloted in November 2007 and changes were made as the result of recommendations made by the pilot sites. The final version was automated and placed on DHR's intranet for State-wide use as of November 2008. After the initial round of data collection and instrument critique, the LSRI was further improved in 2009. In May 2010, an updated version of the LSRI was implemented across the State.

LSRI Activities in 2010

The LSRI was enhanced in May 2010 to add items related to the Family Centered Practice (FCP) model in Maryland – these items were added to the Investigations, Out-of-Home Placements, In-Home Services and APPLA (Another Planned Permanent Living Arrangement) modules.

Additionally, the Investigations and Resources Home program assignment modules were added to the instrument

In 2010, DHR/SSA assumed the lead regarding all issues of the LSRI (instead of RYC acting in this role), including working with DHR's Office of Technology for Human Services (OTHS) on development and enhancements to the instrument, and providing technical assistance to the LDSSs. Additional updates to the LSRI process in 2010 are described below.

Enhanced Scoring Logic and Sampling. Enhancements were made to the logic used to calculate scores for each outcome in the LSRI. Scores are now more reflective of true performance around each of the outcomes in the LSRI. Non-sampled (i.e. those not randomly selected but selected by jurisdictions for local review purposes) and pending or

incomplete cases were eliminated from the scoring process. This work was completed by RYC.

Training on LSRI. Training continues to be conducted in partnernship with the Child Welfare Training Academy (located with University of Maryland the School of Social Work, via a contract with SSA).

Compliance with LSRI Policy. In order to improve state-wide compliance with LSRI casework review policy, the QA team implemented a new process in 2010 that provides regular updates to the Executive Director of SSA on LDSS compliance. These updates identify LDSSs that are out of compliance in completing the required sample cases. Letters are sent to the Director and Assistance Director of these jurisdictions from the Executive Director requiring them to improve performance in this area.

RYC provided one individual LSRI reports to local departments that included scores for the outcomes of safety, permanency, and well-being, and practice areas. Local Supervisory Review Instrument State Data Report 2010 included data from all case reviews submitted by each local department during the period of September 9, 2009 to March 2, 2010. The report reflected the improved scoring logic and sampling approach instituted in 2010. Aggregate data for the local departments and the State were provided to support supervisors in their use of the instrument to identify strengths and areas needing improvement on a case-by-case basis and to develop strategies for improving quality of practice with their caseworkers. Analysis of aggregate data also assisted in identifying systemic issues and training needs. The In-Home scores reflect a general need for improvement. Except for Intervention, all the constructs had a score of 89 or lower indicating need for improvement. Intervention had the highest score of 92 and Reevaluation had the lowest score of 75. The majority of the Out-Of-Home constructs reflect need for improvement with scores of 89 or lower. Permanency 1, Well-Being-2 and Assessment all had scores above 90 reflecting a strength. The lowest score was on services with a score of 79. The APPLA constructs were evenly divided between those in need of improvement and those of a strength. The highest score was 100 for Transition and the lowest score was 59 for Aftercare. Four out of five constructs scored above 90 indicating strengths. Intervention, with a score of 80, was the only area in need of improvement. The highest score was 94 on Services.

Findings from the 2009 and 2010 Local Supervisory Reviews (Closson & Kaye, 2009[1]; Gregory & Esaki, 2010[2]) can be found on the Ruth H. Young Center for Families and Children website.

Next Steps: LSRI

The revised LSRI (May 2010) was successfully introduced to the LDSSs However, data issues on the transmission of certain data elements by RYC were inadvertently introduced during the process of conversion to the new version, , which has delayed the production o completed LSRI reports for the time period from March 2010 through now. Until these data issues are addressed, complete LSRI reports cannot be accurately generated. RYC will, however, continue to produce reports excluding the few affected items until either RYC or DHR Office of Technogology for Human Services (OTHS) can identify and implement a solution.

A validity and reliability study on the LSRI was anticipated during 2010, however due, availability of resources, this was not possible. Depending on the availability of resources and the capacity of RYC to produce regular LSRI reports for the State and the LDSS, validity and reliability testing will be rescheduled for FY2012.
DHR/SSA Quality Assurance staff continue to work closely with the Local Departments of Social Services to improve the LSRI. Several items have already been identified as problematic since implantation in May 2010; these items will be corrected in the coming fiscal year. Further planned enhancements for the tool include RYC providing monthly reports for the LDSSs, which will allow the State and local departments to obtain quality service information at any time.

Maryland is currently developing it's federal child welfare Program Improvement Plan (PIP), in response to the federal Child and Family Services Review (CFSR). The PIP requires the measurement of several CFSR items, and the LSRI has been selected as the most appropriate means to do so. Data from the LSRI will be included in quarterly reports

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1 http://www.family.umaryland.edu/ryc_research_and_evaluation/child_welfare_research_files/2008%20Local%20Supervisory%20Review%20Report.pdf

2 http://www.family.umaryland.edu/ryc_research_and_evaluation/child_welfare_research_files/LSRI%20data%20report%20May%202010.pdf

to the federal Department of Health and Human Servicves/ Administration for Children and Families/ Children's Bureau as evidence of progress on selected strategies and goals.

Maryland Foster Parent Survey

The Maryland Foster Parent Survey was developed by RYC in partnership with DHR/SSA and with assistance from the Annie E. Casey Foundation, to solicit feedback on foster parents' perceptions of the training and support provided to them by DHR/SSA, and to collect suggestions for improvement. In partnership with DHR/SSA, researchers at the RYC created a phone survey, collected survey data, and analyzed the foster parent survey data. Quarterly reports of quantitative data and semi-annual thematic memos of qualitative data have kept DHR/SSA informed of emerging findings throughout the project year.

Sampling

New samples of foster parents who have exited (e.g. are no longer interested in hosting foster children through the LDSS or the state of Maryland) are provided to RYC by DHR/SSA quarterly. At the same time, a sample of over five thousand continuing foster parents is provided to RYC by DHR/SSA from which a stratified random sample, based on geography, is pulled each quarter. Two hundred eight (208) foster parents and former foster parents were interviewed between January 1, 2010 and October 31, 2010

Reporting

RYC submitted three quarterly reports to DHR/SSA summarizing the quantitative data along with two thematic memos highlighting the qualitative themes. A list of exited foster parents wanting to return was submitted to DHR/SSA quarterly in addition to a list of foster parents who wanted to be contacted about service improvement ideas. A final report that fully processes the quantitative and qualitative data and provides recommendations for recruitment and retention practices was also submitted for the period of July 1, 2009 to June 30, 2010.

Initial analysis of the responses from foster families regarding their experiences suggests that recruitment and retention efforts should focus on activities that empower foster parents in ways that can assist them in sustaining the foster family. Several strategies have been identified as possible ways to attract potential foster parents and to sustain current

foster parents. Engaging satisfied foster parents as recruiters could be helpful in enlisting new foster parents, considering that they often have a great deal of knowledge and experience regarding the system and could serve as models and provide mentoring and guidance. Based on the quantitative and qualitative survey responses the following strategies are recommended to help Maryland effectively retain current foster parents:

- Increase support for relative caregivers,
- Develop clear mechanisms to support foster families with behavior modification techniques for children who exhibit emotional and behavioral problems,
- Engage foster parents as recruiters, and
- Share accurate and timely information on matters such as services and resources available for foster families and the youths in their care.

The complete 2010 annual report of the Maryland Foster Parent Survey (Moothart, Gregory, & Esaki, 2010[3]) can be found on the Ruth H. Young Center for Families and Children website.

Next Steps: Foster Parent Survey

RYC will continue to contact both exiting and continuing foster families in order to collect important information related to the experience of Maryland's foster families in order to help develop ways to increase foster family retention and recruitment. A revised foster parent survey that is longitudinal in nature should be seriously. A longitudinal survey would allow DHR/SSA and RYC researchers to collect a richer picture of foster parents' experiences in the system, thus, providing new information to DHR/SSA that may enhance practice and policy decisions and pinpoint areas where targeted interventions and supports can be utilized to retain current foster families and increase overall foster family satisfaction.

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3 http://www.family.umaryland.edu/ryc_research_and_evaluation/child_welfare_research_files/Foster%20Parent%20Survey%20Annual%20Report%20August%202010.pdf

Evaluating Family Centered Practice in Maryland

Family Centered Practice (FCP) is an approach to child welfare that aims to engage families in the decision making process regarding their child and increase positive outcomes for children. The Maryland FCP practice model, which was introduced across the state in 2009-2010, is based on a set of core practice values including: (1) an understanding that "place matters" for children in Maryland, (2) the need to build upon family strength and expertise, (3) a respect for families and an understanding for the need to have cultural sensitivity when working with diverse families, (4) the recognition that to be successful DHR/SSA and the LDSSs need to collaborate with communities, and (5) the continuing desire to manage using data and to utilize data driven practices. The core strategies of implementing the FCP model includes: (1) the consistent and effective use of Family Involvement Meetings (FIMS) at specific trigger points, (2) the building of community partnerships to meet the needs of families where they live, (3) the recruitment and retention of kinship and community based resource homes, (4) effect and consistent local department self evaluation, and (5) enhanced policy and practice development.

Evaluation Components

The RYC plan to evaluate Family Centered Practice was approved by DHR/SSA in 2009 and implemented in 2010. As per agreement between DHR/SSA and RYC, the components of the formal evaluation focus on (1) the process of implementing FCP across the state, (2) a description and process evaluation of the initial changes in practice, (3) the tracking of changes in children and families' level of engagement in child welfare services, and (4) ongoing documentation of the child and family outcomes of safety, permanency, and well-being. Researchers at RYC, in collaboration with DHR/SSA staff, have developed a three part evaluation plan for measuring changes in organizational climate (in relation to family centered practice), worker attitudes and practices, and outcomes for children and families. Details of the evaluation plan and successful roll-out of the FCP implementation plan are detailed below.

Component 1: Process Evaluation

The process evaluation focuses on the implementation efforts at each local DSS. The purpose of the process evaluation is to determine the extent to which the training is implemented and how well each LDSS moves into the FCP paradigm. The process evaluation includes

evaluation of program inputs, activities, and outputs with a focus on training and implementation efforts at each local DSS. The process evaluation includes: (1) Documentation of all program activities and efforts, (2) Implementation of seven focus groups with local departmental staff in each region. As of December 2010, three focus groups in Western region, Baltimore City, and Southern region were conducted. (3) Ongoing feedback of implementation challenges to DHR/SSA throughout the roll-out phase.

Component 2: Practice Evaluation

The purpose of the practice evaluation is to develop initial fidelity criteria for the FCP model and to evaluate changes in practice around the FCP core values and strategies. The practice evaluation component includes documenting implementation of the FCP model in terms of: (1) Tracking the number of Family Involvement Meetings (FIMS) held per month per jurisdiction and tracking the incidents that triggered them, (2) Measuring worker's attitudes towards integration of FCP principles in practice through the use of a standardized measure included in a statewide online survey that is distributed to all Child Welfare staff at six month intervals, and (3) Documenting efforts to engage family members in assessment, planning, and intervention by (a) increasing the level of detail that is collected by local jurisdictions about each of their FIMS and by (b) training child welfare staff and providing technical support to local jurisdictions to increase the engagement of youth in case planning and preparation for their transition to adulthood, in collaboration with the Youth Engagement Model that is currently being developed by DHR.

Component 3: Outcome Evaluation

The purpose of the outcome evaluation is to determine changes in safety, permanency, and well being following the implementation of FCP. The outcome evaluation is focused on using existing child welfare data from MD CHESSIE and the LSRI to examine the effectiveness of FCP on: (1) increased out-of-home placement diversion, (2) increased permanent placement with relative caregivers, and (3) decreased time in out-of-home care.

Data Sources

The evaluation and ongoing assessment of Maryland's FCP initiative is enhanced by data collected as part of regular agency practice and supplemented by a survey of local department staff attitudes towards

FCP. Data sources that will be used to evaluate Maryland's FCP include:

- **Local Supervisory Review Instrument (LSRI) Data.** The LSRI is a tool to help supervisors examine caseworker quality of practice and is completed by supervisors on a randomly selected sample of cases each month. Data from the LSRI is analyzed semi-annually in relation to FCP evaluation requirements.
- **Report of Family Involvement Meetings (FIMs).** Reports of FIM activity are provided to DHR/SSA monthly by LDSS a FIM facilitator or a local department administrator. RYC researchers analyze trends in FIM activity by month and provides statewide and jurisdiction level reports.
- **Family Centered Practice Progress Report**. Submitted by a LDSS administrator at the initiation of training, and at 6 and 12 months following the training. This document is used to target TA efforts as well as evaluate systemic changes at each local department.
- **Family and Youth Feedback.** FIM feedback forms from family members are currently being developed by DHR/SSA and will be collected by each LDSS. Researchers at RYC will analyze data from these forms quarterly and provide statewide and jurisdiction level reports when they become available from DHR/SSA.
- **Survey of Attitudes & FCP Practices.** An electronic survey was utilized as a baseline view of LDSS worker attitudes on the FCP process. A follow up electronic survey will be administered to all local department staff to measure organizational climate, attitudes and practices related to FCP. The follow-up surveys was sent out 6 months post the date of the local department submission of their strategic plan to measure changes over time.

Implementation of FCP Evaluation

Progress in 2010 on the FCP evaluation is summarized below. Further details are provided in the complete annual Family Centered Practice report available on the RYC website (Hayward, Melz, & DePanfilis, 2010[4]).

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(footnote continued)

Process Evaluation

The FCP initiative was rolled out beginning July 2009 and by June 30, 2010, 1,735 child welfare staff (approximately 95% of the state's child welfare workforce) had participated in a two-day training on FCP, which was provided regionally by a collaboration of the Child Welfare Academy, Annie E. Casey consultants, and local department child welfare staff. At the end of each FCP training session, participants were presented with a feedback form and asked to evaluate the training. Overall, feedback from trainees was positive. The goal of the training initiative was to reach the entire child welfare workforce, and by this standard this effort was highly successful.

DHR/SSA also made significant efforts to engage providers and stakeholders in the FCP implementation process. A total of 261 foster care provider staff were trained as of November 30, 2010 and trainings continued throughout 2010. Stakeholders, including representatives from the provider and foster parent advocacy community, the legal system, advocacy groups and RYC staff, have participated in monthly FCP oversight committee meetings. The FCP oversight committee monitors and provides policy and technical assistance recommendations.

Another task of the FCP implementation was to gauge staff perceptions of their jurisdiction's organizational climate, their perceptions of their agency's FCP efforts, and their personal attitudes toward FCP. A total of 810 workers (caseworkers, supervisors, and agency administrators) statewide completed an online survey between July 2009 and March 2010. Given an approximate child welfare workforce of 1,834, the response rate for the survey was 44%. A follow-up online survey has been created and will be fielded to each jurisdiction six months after the submission of their FCP implementation plan (see below), to measure change in these measures across time.

Each local jurisdiction was also asked to complete an FCP progress form at the initiation of their FCP training, to provide baseline

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http://www.family.umaryland.edu/ryc_research_and_evaluation/child_welfare_research_files/FCP%20Evaluation%20Annual%20Report%202010.pdf

information about the extent to which they already integrated FCP core values and strategies in their practice. RYC researchers presented data from the progress reports and staff survey to each local jurisdiction at seven regional orientation meetings. Each local jurisdiction was then asked to develop a strategic plan for the implementation of FCP and to submit their plan to DHR/SSA within 30 days. As of November 18, 2010, all but one jurisdiction has submitted their strategic plan.

Recommendations for FCP Process:

- A clear plan for the provision of implementation technical assistance and a corresponding timeline should be developed for each local jurisdiction in partnership with them.
- The FCP Oversight Committee should be more actively participated in reviewing the development, approval, and implementation of LDSS FCP strategic plans.
- Feedback mechanisms for implementation strategies should be developed following implementation planning at the local level.
- Jurisdictional leadership should address aspects of their organizational climate – as measured in the staff survey and reported to them – that may present a barrier to the implementation of FC.

Practice Evaluation

In order to document current practice and changes to practice related to FIMS following FCP implementation, local jurisdictions have been submitting aggregate reports of FIMS conducted, related triggers, family and community participants, and child placement outcomes after FIMS. Data from these reports is aggregated monthly and will serve as baseline data and inform strategic implementation plans.

Plans are in place to examine the new FCP items in the LSRI to track regional fidelity to FCP practice. Tracking of those data will commence in January 2011.

Recommendations for FCP Practice:

- Mechanisms for capturing family engagement are needed. Quality Assurance case reviews will include measures of family engagement; however, these data will not be available statewide during the FCP evaluation period

- FIM reporting standards and consistent policy regarding triggers are needed across the state. The monthly reports on FIMS by local jurisdictions are often missing data, and jurisdictions report that they do not consistently hold FIMS in response to mandatory triggers.
- Participant satisfaction with the FIM process should be regularly collected in a standardized format by jurisdictions and those data should be collected and analyzed by DHR in partnership with UMD-SSW.
- More information on the FIMS process is needed to make meaningful conclusions about out-of-home placement diversions and the inclusion of family members in those decisions.

Outcome Indicators

Baseline data on key FCP related indicators: 1) the number of children in out-of-home care; 2) length of time in out-of-home care; 3) the percent of children in out-of-home care who are in family homes; and 4) the percent of children in out-of-home care who are placed with siblings is being tracked for purposes of this evaluation. A baseline of December 2009 was selected and data are being analyzed at 6 and 12 months following the conclusion of training in each jurisdiction.

Recommendations for Measuring Outcomes:

- Due both to the design of the FCP evaluation and to the fact that there are other state initiatives that are being implemented that may also impact child welfare and out-of-home placement, one cannot conclude that any improvements in these child welfare outcomes, measures pre- and post-FCP implementation, are causally associated with the rollout of FCP.
- Local jurisdictions would benefit from technical assistance on the use of data to inform and improve practice at the organization and case level.

Next Steps: Evaluation of Family Centered Practice in Maryland

Continued implementation of the FCP evaluation according to plan will be pursued. As data are collected and assessed, DHR/SSA will receive a semi-annual update and a final annual report as to the findings of the evaluation.

Data-Driven Staffing Allocation

The Child Welfare Accountability Act referencing Human Services Article §4–301 requires that "sufficient numbers of qualified child welfare staff…are hired and retained in order to achieve caseload ratios in child welfare services consistent with the Child Welfare League of America caseload standards." (Maryland Family Law, Section 1310). Given their influence on the quality of child welfare services, outcomes for children and families served by child welfare, and retention of child welfare staff, staffing allocation is an important component of the work of SSA. This chapter reviews progress made in 2010 for use of data to estimates staffing needs for in-home services.

Safety and Risk Based Categories

RYC assisted DHR/SSA to develop a methodology to calculate caseload ratios in child welfare services for the state in calendar year 2008. This methodology was designed in partnership with members of an In-Home Services Workgroup called to discuss the development of a safety and risk based system of in-home service delivery and to examine staffing patterns needed to meet Child Welfare League of America's (CWLA) caseload recommendations. Members of the workgroup included SSA program staff, leadership from local DSSs, the National Resource Center for Child Protective Services, and faculty from RYC.

The methodology developed in Maryland was reviewed and approved by the Child Welfare League of America (CWLA) and reported as part of the 2008 Child Welfare Accountability legislative report: *Quality Assurance Process in Maryland Child Welfare: 2nd Annual Child Welfare Accountability Report*. In their review, CWLA commended Maryland for the use of the data in making staffing allocation decisions. The Risk and Safety based methodology and processes are included in Appendix A.

Continued Monitoring of Risk and Safety

The initial analysis of the in-home and investigations files from the data tables in MD CHESSIE revealed missing safety assessment, risk assessment, or both in the electronic record data fields in many cases. In the original 2008 analysis, not all assessments were available in MD CHESSIE. Only 53% of required data were available for in-home cases through the electronic record data fields and only 63% of required data were complete in the electronic record data fields for investigations. In order to complete the caseload ratio report, local departments were asked

to supply the information that was missing from the electronic record. This process increased data completeness from 53% complete to 85% complete for in-home cases and from 63% complete to 87% complete for investigations.

The ability of local departments to supply missing information suggested that these assessments are not truly missing, but rather stored in a manner that is not easily accessible through the electronic record for analyses. Anecdotal information suggested that these assessments were being stored in MD CHESSIE using an electronic filing system (the storage of a document in MD CHESSIE) instead of being entered into the available data fields. Information stored in the electronic filing system cannot be utilized without that information being transferred to the available MD CHESSIE data fields.

Over the last two years the completeness of the data elements for the Risk and Safety assessments in the MD CHESSIE system has been monitored. Reports on data completeness have been submitted to DHR/SSA throughout the year. Below are updated reports on the presence of Risk and Safety assessment information for investigations and in-home services.

Investigations were only included in this analysis if the records were not expunged. As can be seen from the Investigations table below the presence of the Safety Assessment and Risk Assessments vary from month to month with the general trend being that 90% or more of the assessments are in the electronic tables from MD CHESSIE. These values are much higher than the 63% seen in the initial attempt to examine Safety and Risk Assessment information from Investigations.

The next table presents the presence of a Safety or Risk Assessment for In-home cases. As can be seen from the In-Home table below the presence of the Safety Assessment and Risk Assessments vary from month to month with the general trend being that 67% of the In-home cases have record of a Safety Assessment and 77% have record of a Risk Assessment in MD CHESSIE. These values are higher than the 53% seen in the initial attempt to examine Safety and Risk Assessment information from In-home services.

Presence of Safety/Risk Assessment Information for Investigations (%)

	Safety Assessment present	Risk Assessment present	Risk or Safety Assessment present
June, 2010	88.24	86.22	92.89
May, 2010	92.96	91.76	97.39
April, 2010	91.18	91.91	96.97
March, 2010	91.93	92.94	97.48
February, 2010	93.32	95.45	98.48
January, 2010	91.82	93.48	97.87
December, 2009	93.81	93.30	98.07
November, 2009	92.53	95.10	98.07
October, 2009	93.13	95.35	98.78
September, 2009	94.11	96.07	98.58
August, 2009	93.88	95.84	99.08
July, 2009	94.45	95.30	98.67
June, 2009	91.14	88.00	95.92
May, 2009	93.16	92.34	98.22
April, 2009	93.80	93.42	98.68
March, 2009	93.70	94.73	97.84
February, 2009	95.11	94.13	99.02
January, 2009	94.50	95.44	98.95

Presence of Safety/Risk Assessment Information for In-Home Services (%)

	Safety Assessment present	Risk Assessment present	Risk or Safety Assessment present
June, 2010	66.93	77.71	85.75
May, 2010	67.82	77.36	85.68
April, 2010	67.51	77.05	85.52
March, 2010	67.56	76.95	85.50
February, 2010	67.43	77.78	85.36
January, 2010	67.72	76.34	85.18
December, 2009	66.99	75.55	84.56
November, 2009	66.71	74.19	84.18
October, 2009	65.92	74.40	83.97
September, 2009	64.41	75.13	83.74
August, 2009	64.31	74.25	83.19
July, 2009	65.30	74.65	83.58
June, 2009	58.8	70.2	78.2
May, 2009	59.4	69.0	77.7
April, 2009	59.8	67.8	77.2
March, 2009	59.6	66.3	76.6

February, 2009	59.1	66.7	76.6
January, 2009	59.2	65.9	76.3

Next Steps: Data Driven Caseload Calculation

As the completeness of the required data elements increases in MD CHESSIE, these data will be used to reevaluate the caseload calculations. Over the last year some stability has been reached in the presence of the Risk and Safety Assessment information in MD CHESSIE. But, there remains a large amount of missing data (around 10% of the Investigation Cases and 25% or more of the In-home Cases). It is recommended that DHR/SSA in collaboration with RYC look at the cases where Risk and or Safety Assessments are not recorded to determine if there are systemic or practice based reasons for not entering (or possibly not completing) these assessments. This information will help determine whether the information available is adequate to once again begin reporting on the caseload calculations as was originally planned.

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Appendix A: Data Driven Caseload Calculation Processes

Risk

Maryland utilizes the Maryland Family Risk Assessment (MFRA) instrument to assess five domains that, if present, may indicate the likelihood of child maltreatment in the future. The five domains are child, caretakers, family, ecological environment, and maltreatment history. Workers rate each family at low, moderate, or high risk based on clear rating guidelines and then provide an overall rating.

Categories of Risk

Level	Description
High Risk	Extensive negative family conditions and circumstances are present and influencing family functioning
Moderate Risk	Even distribution of positive and negative conditions and circumstances; negative influences are serious
Low Risk	More positive than negative conditions and circumstances; negative influences are low to moderate seriousness
No Risk	Generally positive family conditions and circumstances; negative conditions are low to none

Safety

Maryland utilizes the SAFE-C to assess 19 safety influences that, if present, suggest possible harm now or in the future. Workers assess each item as present or absent and provide an overall rating of safety.

Categories of Safety

Level	Description
Unsafe	At least one safety threat identified without a safety plan in place; the caregiver will not agree to a safety plan, or the danger cannot be addressed with a safety plan
Conditionally Safe	At least one safety threat was identified but there is a safety plan in place to address safety threat
Safe	No identified safety threats

Level of Service Definitions

Three levels of service were defined to coincide with CWLA's service definitions and caseload ratio recommendations. The level of effort and caseload associated with each level of service is shown below.

Levels of Service

Levels	Level of effort (case closure criteria):	Caseload
L1 Intensive	Minimum of 3 hours of face to face time by the social worker (case workers) for each case, face to face time does not include travel (unless transportation includes the child) or paperwork. Step down when safety can be managed by the caregivers to the appropriate level based on risk to the child. Safety and Risk will be reassessed every 3 months with an administrator level review at 6 months.	1-6
L2 Placement Prevention	Minimum casework intervention per week is 1.5 hours face to face per week. Step down based on the level of risk to the child. Safety and Risk will be reassessed every 3 months with an administrator level review at 6 months. Instances where a child is informally placed with relatives and services are provided to the relatives with the goal of reunifying fit into this category.	1-12
L3 Stabilization - Family Services	Minimum of 1 hour face to face per week (possibly set up as 2 hours over 2 weeks). Safety and Risk will be reassessed every 3 months with an administrator level review at 6 months. Level 3, could be a step down level only with families not starting here, unless the family is a repeat admission as this level is Safe and low risk.	1-15

Assignment to Levels of Service

The methodology assigns families to levels of service based upon their risk and safety assessments as depicted above. Families where the child is unsafe will be placed into level 1 for intensive services. Families where the child is safe will be assigned to other levels based on the risk assessment as seen below.

Risk/Safety-Based Service Provision

	High Risk	Moderate Risk	Low Risk	No Risk
Unsafe	Level 1: Intensive			
Conditionally Safe Safe	Level 2: Placement Prevention		Level 3: Stabilization-Family Services	

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