

Children's Administration

**COMPLIANCE PLANS IN
RESPONSE TO BRAAM OVERSIGHT PANEL
MONITORING REPORT 8**

April 30, 2010

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INTRODUCTION

This document describes the corrective actions that the Department of Social and Health Services (DSHS), Children's Administration (CA) will implement to support necessary practice improvements to comply with the Braam Settlement Agreement.

In our last compliance plan report to the Panel we described our new approach to integrate the Settlement Agreement into our ongoing implementation, quality assurance and practice improvement activities.

CA has continued to evolve the comprehensive planning process we are using to develop and implement compliance plans. The plans in this report reflect deliberate efforts to co-opt thoughtful contributions from a broad representation of individuals involved in the child welfare system. The inclusive process demonstrates CA's commitment to have the compliance plans reflect our best thinking about key strategies to achieve desired outcomes for children and families we serve.

The strategy development process was initiated with a series of topic specific conference calls that involved CA social workers, supervisors, and program leads. Members of external advisory committees were also invited to participate, including:

- Children, Youth, and Family Services Advisory Committee
- Indian Policy Advisory Committee
- Washington State Racial Disproportionality Advisory Committee
- Passion to Action, Foster Youth and Youth Alumni Advocates
- Parent Advocacy Committee
- Foster Care Consultation Team (1624 Committee)

CA's Statewide Quality Assurance Team reviewed feedback gathered from the calls and consulted with program leads to identify and refine recommendations for CA leadership consideration. CA will continue to work with and involve internal CA staff as well as our external advisory committees and partners in the improvement plan process.

In addition to the specific improvement strategies identified for each outcome, seven foundational strategies are included in this report beginning on page 35. These strategies are foundational in nature and encompass strategic areas of CA focus with broad impact. While these strategies are fundamental in nature, they are included at the end of the report to bring to the forefront the particular practice improvement strategies that are specific to each outcome and avoid replication for each outcome they impact.

This compliance plan follows closely behind the February 2010 compliance plan report. Some of the strategies in this report build on strategies included in the previous report. In addition, in recognition of the variable time needed to develop and implement different strategies, the timelines and realization of results will be both short and long-term. CA anticipates seeing an impact in FY 2010 on some of the outcomes and an even greater impact for FY 2011.

BACKGROUND

In the Braam Oversight Panel's 8th Monitoring Report, the Panel concluded that CA performance failed to reach the FY09 benchmarks for 24 outcomes set forth in the Implementation Plan. Pursuant to the Settlement Agreement, a compliance plan is required for each of these outcomes. Included in this report are compliance plans for 16 outcomes. The Panel determined a new compliance plan is not required for 8 outcomes that were recently approved and/or are in the process of being reviewed by the Panel.

The outcome areas below are items the DSHS Children’s Administration was found out of compliance with that require a new compliance plan be submitted to the Braam Oversight Panel. The matrix provides a brief description of each item and reflects applicable benchmarks and current performance:

Outcome / Action Step	Performance
<p>1. Two or fewer placements</p> <p>The percentage of children who experience two or fewer placements during their current out-of-home episode of care.</p>	<p><u>Benchmark FY09</u> 89%</p> <p><u>CA Performance</u> 80.9%</p>
<p>2. Caseloads At or Below 18 Cases</p> <p>Children will be served by caseworkers with caseloads at or below Council on Accreditation (COA) standards (18 child cases per caseworker) (outcome measure based on the percentage of children served by caseworkers with caseloads at or below COA standards).</p>	<p><u>Benchmark FY09</u> 85%</p> <p><u>CA Performance</u> 65%</p>
<p>3. CHET Screen within 30 Days</p> <p>Children in out-of-home care 30 days or longer will have completed and documented Child Health and Education Track (CHET) screens within 30 days of entering care.</p>	<p><u>Benchmark FY09</u> 80%</p> <p><u>Performance</u> 64 %</p>
<p>4. CHET Shared Planning Meeting within 60 Days</p> <p>A shared planning meeting (SPM) focusing on the CHET screening results will be held within 60 days of each child’s entry into care.</p>	<p><u>Benchmark FY09</u> 85%</p> <p><u>CA Performance</u> FY09 data not available</p>
<p>5. ITEIP Referral</p> <p>Children age 3 and under in out-of-home care will be referred to the Infant Toddler Early Intervention Program (ITEIP) within 2 workdays of identification of concerns about developmental delays from CHET screens.</p>	<p><u>Benchmark FY09</u> 85%</p> <p><u>CA Performance</u> 72%</p>
<p>6. Health and Education Plan Updated Every 6 Months in ISSP</p> <p>Children in out-of-home care will have health and education plans in their ISSPs updated every 6 months.</p>	<p><u>Benchmark FY09</u> 80%</p> <p><u>CA Performance</u> 63%</p>
<p>7. Medically Fragile</p> <p>Medically fragile children will be connected to ongoing and appropriate medical care and placed with caregivers who receive consultation and ongoing training regarding their caretaking responsibilities for the medical condition.</p>	<p><u>Benchmark FY09</u> 90%</p> <p><u>CA Performance</u> 83.5%</p>

Outcome / Action Step	Performance
<p>8. Monthly Visits</p> <p>Children will receive a private and individual face-to-face health and safety visit from an assigned caseworker at least once every calendar month, with no visit being more than 40 days after the previous visit.</p>	<p><u>Benchmark FY09</u> 90%</p> <p><u>CA Performance</u> 14.8%</p>
<p>9. Victims of CA/N by Licensed Foster Parent or Facility Staff</p> <p>The percentage of children who are not victims of a founded report of child abuse or neglect by a foster parent or facility staff member will meet or exceed the federal Child and Family Services Review standard (CFSR round 2).</p>	<p><u>Benchmark FY09</u> 99.68%</p> <p><u>CA Performance</u> 99.62%</p>
<p>10. DLR Investigation</p> <p>All referrals alleging child abuse and neglect of children in out-of-home care will receive thorough investigation by the Division of Licensing Resources (DLR) pursuant to CA policy and timeline and with required documentation.</p>	<p><u>Benchmark FY09</u> 100%</p> <p><u>CA Performance</u> 82.9%</p>
<p>11. All Siblings Placed Together</p> <p>Children in out-of-home care will be placed with all siblings who are also in out-of-home care whenever possible.</p>	<p><u>Benchmark FY09</u> 70%</p> <p><u>CA Performance</u> 60.9%</p>
<p>12. Siblings Placed With At Least One Sibling</p> <p>Children in out-of-home care will be placed with at least one sibling who is also in out-of-home care whenever possible.</p>	<p><u>Benchmark FY09</u> 90%</p> <p><u>CA Performance</u> 80.9%</p>
<p>13. High School Graduation Rate</p> <p>The percentage of youth in out-of-home placement in grade 9 who remained in placement continuously through grade 12 who graduate from high school on time with a regular or adult (IEP) diploma, including students with disabilities who graduated within the number of years designated in their IEP, will increase.</p>	<p><u>Benchmark FY09</u> 80%</p> <p><u>CA Performance</u> 52.8%</p>
<p>14. Youth Transition Exit Staffing</p> <p>A multi-disciplinary staffing meeting will be held six months prior to a youth's exit from foster care to address issues related to transition to independence.</p>	<p><u>Benchmark FY09</u> 85%</p> <p><u>CA Performance</u> FY09 data not available</p>

Outcome / Action Step	Performance
<p>15. Frequency of Children Running From Care</p> <p>The percentage of children who run from out-of-home care placements during the fiscal year will decrease as indicated in the benchmark table below.</p>	<p><u>Benchmark FY09</u> 2.5%</p> <p><u>CA Performance</u> 3.4%</p>
<p>16. Median Days of Children on Run Status</p> <p>The median number of days that children are on runaway status will decrease as indicated in the benchmark table below.</p>	<p><u>Benchmark FY09</u> 30 days</p> <p><u>CA Performance</u> 27 days</p> <p><i>Statewide benchmark was achieved, but regional requirements were not met. Performance in Region 5 was more than 5 days higher than the statewide benchmark. Therefore the overall benchmark has not been reached.</i></p>

CHILDREN’S ADMINISTRATION COMPLIANCE STRATEGIES

The Children’s Administration is implementing the following strategies to continue to improve practice and achieve goals in the 16 outcome areas addressed in this compliance plan report.

PLACEMENT STABILITY

TWO OR FEWER PLACEMENTS

GOAL 1, OUTCOME 2: The percentage of children who experience two or fewer placements during their current out-of-home episode of care will increase as indicated in the benchmark table below. *This outcome measure is based on the percentage of children/youth entering care during the two previous fiscal years with 2 or fewer placements [with time-in-care specifications based on entry year].*

Benchmarks Required for Compliance and CA Performance

	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	7/15/08	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	Baseline	87%	88%	89%	90%
CA Performance*	84.7%	85.5%	86.4%	80.9%	1/1/11

* The significant drop between FY08 and FY09 performance on this outcome is attributable to the conversion of data and how it is structured differently in the CAMIS and FamLink systems.

Providing stability and continuity is essential for children’s personal development and achievement. CA is committed to increasing the stability of children in care and recognizes continuity in relationships with parents, siblings, and school are crucial. In addition, relative caregivers and caregivers who experience support are more likely to remain committed to the children and youth in their care.

Strategy 1: Develop and Implement Caregiver Support Plan

Develop and implement a new practice expectation for social workers to develop a support plan with caregivers when indicated by the needs of the child, placement of a sibling group, or a newly licensed foster home. Policy, practice expectations, and implementation materials will be developed through a collaborative process involving social workers, licensors, relatives, foster parents, and community providers. The implementation package will address the following:

- ❖ A menu of available supports, resources, training, etc. to assist in the development of the Caregiver Support Plan.
- ❖ Assessment process and/or tool to help identify the strengths and needs of the caregiver. CA will explore the use of tools that help assess caregivers ease or difficulty of caring for a child placed in their care and caregiver assessment tools used by the Division of Licensed Resources.

- ❖ Licensors and social workers working together when possible to develop support plans for licensed foster families, especially for children with high risk behaviors and newly licensed foster families.
- ❖ Revisions to define and integrate the new practice expectation into CA policy and procedures.

(For caregivers of SAY/PAAY youth: April 30, 2010; for caregivers of Medically Fragile children/youth: July 2010; for other caregivers: April 2011)

Strategy 2: Develop and Implement Placement Coordinator Protocol, Guidelines and Training

Convene a statewide workgroup comprised of CA staff and representatives from birth parents, youth, private agencies, and caregiver organizations to develop a standard statewide protocol, guidelines, and training for Placement Coordinators and staff matching children with licensed placement resources. The purpose is to strengthen and promote the quality, consistency, and outcomes of placement decisions to better preserve and promote a child's connections to family, siblings, and their community. The statewide workgroup will develop the following:

- ❖ Standard placement protocol that will be used statewide by Placement Coordinators and staff matching children with licensed placement resources. The protocol will address decision-making that supports the quality and consistency of selecting placement resources that preserve and promote a child's connections to family, siblings, and their community and the order of priority when considering factors that influence placement selection. The protocol will include steps to maximize the use of licensed caregiver resources for sibling groups and identify minimum practice expectations to be completed prior to requesting a licensed out of home placement resource (e.g. FTDM, Relative Search, etc).
- ❖ Training curriculum, materials, and implementation plan to provide Placement Coordinator and staff matching children with licensed placement resources training on the following:
 - How to use the FamLink Placement Vacancy Report to identify capacity/availability of licensed foster homes.
 - How to use FamLink to identify and match caregiver preferences with characteristics of children/youth.
 - Caregiver considerations, including the need to carefully consider commitment to sibling groups, location, individual attributes, strengths and needs, family constellation, and ability to meet long term needs.
- ❖ Additional recommendations for CA Leadership Team consideration regarding placement decisions to promote placement stability, sibling relationships, sibling and family connections, etc.

(Protocol & Guidelines, August 2010; Training, November 2010)

Strategy 3: Enhance Focus on Timely Permanency for Children Residing with Relatives

When children are not able to safely remain at home with their parents, safe placement with relatives has many advantages including maintaining and providing family and cultural connections and placement and educational stability. CA values relative caregivers and is

committed to achieving safe timely permanency for children in out of home care. In that regard, CA is focusing on a number of activities to strengthen existing relative placement practices and to increase the number of licensed relative caregivers. Key areas of focus are outlined below:

A. Strengthen Existing Relative Placement Practices

CA is focusing on strengthening existing relative placement practices, targeting relative search efforts and resources, the quality and timeliness of home studies, and services to relative caregivers through the following actions:

- ❖ Consult with the newly forming Statewide Social Worker and Supervisor Advisory Committee to identify recommendations for CA Leadership consideration to improve application of CA's existing Relative Framework practice expectations and tools. *(July 2010)*
- ❖ Develop and implement action plan to broaden CA staff access to people search software and databases used to identify and locate relatives. *(Action Plan, September 2010)*
- ❖ Create regional relative caregiver social work units to strengthen relative search and support activities, and the quality and timeliness of relative home studies. *(December 2010)*

B. Develop and Implement Plan to Increase Number of Licensed Relative Caregivers

To help move more children in relative placement toward timely achievement of their permanent plan of adoption or Fostering Connection subsidized guardianship, CA will develop and implement a plan to increase the number of licensed relative caregivers. The plan will be developed with input from staff and relative caregivers through the following actions:

- ❖ Convene internal workgroup with social worker and licensing staff representatives to identify and discuss internal barriers and strategies to licensing relatives. *(First meeting held in May 2010)*
- ❖ Consult with the statewide Kinship Care Oversight Committee to identify relative caregivers of dependent children willing to advise CA about barriers and recommendations regarding the licensing process and experience. These relative caregivers will be invited to participate in the statewide workgroup. *(Relative caregivers identified and invitation to join workgroup provided in June 2010)*
- ❖ Continue to partner with the Foster Care Consultation Team (1624 Committee) to revise timeframe requirements for foster parent training to ensure licensed caregivers receive the training they need in a timely manner while being able to spread intensive training requirements over time. *(Proposal developed by September 2010)*

(Statewide plan developed for CA leadership consideration by September 2010)

Strategy 4: Assess Need for Additional Foster Parent Resource Development Strategies

Recruitment of licensed placement resources is an ongoing and fundamental activity for CA. Evaluation of the effectiveness of existing strategies and the need to modify or employ additional activities is an ongoing process. Efforts are underway to continue to implement and examine key foster parent recruitment strategies, including the following:

- ❖ Targeted foster parent recruitment activities for educating the broader community about the need for quality foster homes and soliciting foster parents, including families that will take large sibling groups. This year CA contracted foster parent recruitment providers will receive training on neighborhood based recruitment models. In addition more local offices will receive training and support to work in partnership with their community to strengthen the ratio of children being placed in foster care with local neighborhood placement resources and the need for additional homes that will care for sibling groups. *(Contracted provided will receive Neighborhood Based Foster Parent Recruitment training beginning June 2010 and will be completed by January 2011)*
- ❖ Recruitment strategies to expand the message and assist in the development of more foster homes, using partnerships with faith based organization, businesses and national programs, such as *One Company One Kid* and *One Church One Child*. *(Recommendations by July 2010)*
- ❖ Use of models that facilitate support, respite, continuity of sibling relationships and community connections, such as the Mockingbird Hub Homes, a neighborhood based group of foster homes. *(Recommendations by July 2010)*
- ❖ Strategies to ensure the best use of recruitment and retention contracts for licensed foster homes, including:
 - Strengthen language in recruitment/retention contracts to identify a priority to recruit homes that will take sibling groups. *(August 2010)*
 - Collaborate with contracted recruitment providers, to use information and ideas that have been developed in other states, to identify and implement the most effective ways to recruit licensed foster homes that will care for sibling groups. *(September 2010)*

See foundational strategy for [Family Team Decision Making Meetings](#) (click on link)

Family Team Decision Meetings continue to improve the stability of a child/youth's placement by engaging family, caregivers, and community in a collaborative process when placement decisions are made or the placement is at risk of disruption. CA is continuing to expand the use and effectiveness of Family Team Decision Meetings.

CASELOADS AT OR BELOW 18 CASES

GOAL 1, OUTCOME 3: Social workers will have caseloads at or below Council on Accreditation (COA) standards (8 child cases per caseworker for children with special needs, 18 child cases per caseworker for all other children) (*outcome measure based on the percentage of caseworkers with caseloads at or below COA standards; for measurement purposes, each child with special needs will be counted as 2.25 children*).¹

Benchmarks Required for Compliance and CA Performance

	FY07	FY08	FY09	FY10
Monitoring Report Date	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	Baseline	80%	85%	90%
CA Performance	7/1/08	49.9%	65%	1/1/11

CA remains dedicated to achieving caseloads at or below 18 cases. Lower caseloads provide social workers greater opportunity to better support and focus on their work with children and families through engagement and development and implementation of thoughtful case plans based on comprehensive assessment in partnership with the families and children they affect.

Strategy 1: Provide Supervisors Information, Training, & Expectations for Achieving Timely Permanency

Strengthen social work supervisor practice by increasing their knowledge and understanding of effective permanency planning, required timelines, and the critical role they play through the following actions:

- ❖ In partnership with the newly forming Statewide Social Worker and Supervisor Advisory Committee develop and provide information and training for supervisors to support effective permanency planning, including permanency planning guidelines, legal requirements, concurrent planning, and the role of the supervisor. (*December 2010*)
- ❖ Develop and implement target performance expectations for social workers for achievement of safe and timely permanent plans. For example, adoption social workers target completion of (number) of adoptions each year. (*Targets Set by August 2010, Communicated September 2010, Reflected in Annual Performance Development Plans in Year 2011*)

¹ The Braam Oversight Panel modified this requirement and agreed that Children's Administration does not need to create a definition for children with special needs or use a different case weight for such children in caseload calculations. See Minutes of Braam Oversight Panel meeting, December 8, 2008.

Strategy 2: Increase Number of Permanency Planning Partnership Projects

Increase the number of effective partnerships with courts and child welfare partners that focus on facilitating timely completion of permanent plans, such as the Casey Family Program Permanency Round Table project and the Table of 10 Court Improvement Project, through the following actions:

- ❖ Inventory existing regional permanency planning partnership projects. *(June 2010)*
- ❖ In partnership with Casey Family Programs, reframe and expand the Permanency Round Table project to specifically target children across the state with the greatest length of stay. Permanency Round Tables provide an intensive child-specific permanency planning focus and will be used to help achieve permanency for children/youth by reducing their length of stay in foster care. A FamLink report identifying children with the greatest length of stay will be used to target and prioritize areas of focus and inform statewide planning. (Statewide plan in partnership with Casey Family Programs by August 2010)
- ❖ Meet with the Table of 10 Court Improvement Project lead to identify and coordinate statewide implementation planning efforts and shared goal to expand this partnership project as resources and funds permit. *(August 2010)*
- ❖ Provide regions information about formal permanency planning partnership projects, statewide implementation plan and steps to initiate and/or expand in their region. *(September 2010)*

(See Attachment 1, Casey Family Program Permanency Round Table Project Overview)

(See Attachment 2, Table of 10 Court Improvement Project Overview)

Strategy 3: Enhance Focus on Timely Permanency for Children Residing with Relatives

See description for Strategy 3 under [Placement Stability](#) (click on link)

Strategy 4: Develop and Provide Supervisors Case Assignment Practice Guidelines

In partnership with the Statewide Quality Assurance Team and the newly forming Statewide Social Worker and Supervisor Advisory Committee develop supervisor guidelines to support a more deliberate and strategic case assignment process, including consideration given to the needs of the case, the strengths of the case worker and supervisor, existing workloads, vacancies and newly hired staff. *(November 2010)*

MENTAL HEALTH

CHILD HEALTH & EDUCATION TRACKING (CHET) SCREENS COMPLETED WITHIN 30 DAYS

GOAL 1, OUTCOME 2: Children in out-of-home care 30 days or longer will have completed and documented² Child Health and Education Track (CHET) screens within 30 days of entering care.

Benchmarks Required for Compliance and CA Performance

	FY07	FY08	FY09	FY10
Monitoring Report Date	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	60%	70%	80%	90%
CA Performance*	47.0%	63.3%	64.0%	1/1/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

The healthy development of children in out of home care is a fundamental priority of the Department. Good health and emotional well being increase the likelihood of developmental, social, and educational achievement. To help address this need all children who are expected to remain in care longer than 30 days receive a Child Health and Education Tracking (CHET) screen. The CHET screening assesses the child's physical health, development, emotional/behavioral health, education, and family/social connections. The screening provides the social worker and caregiver important information about the child's current health and well-being within 30 days to help develop an effective case plan.

Strategy 1: Increase Timely Documentation of Children's Placement Information in FamLink

Documenting children's placement information in FamLink is a critical practice expectation to ensure the location of children placed in out of home care is known at all times and accessible to staff statewide. Timely documentation of children's placement information ensures notification as early as possible occurs for the Child Health & Education Tracking (CHET) screen to be initiated and the child's medical coupon issued. To increase the timeliness of placement information being entered into FamLink, CA will take the following actions:

² For Braam purposes, a completed and documented CHET is one in which age-appropriate screenings have been completed for all domains: Medical (EPSDT completed for all children); Developmental (developmental screening completed for children ages 0-60 months); Emotional-behavioral (screening completed for children ages 3 months to 18 years); Educational (educational records received for school-aged children); and Connections (for all children).

- ❖ Ensure the location of children/youth, placed under CA care and authority; have their residence (physical location) documented in FamLink in accordance with policy by supervisor's reviewing FamLink during their monthly case review. *(Ongoing)*
- ❖ Provide regions a list of children/youth that did not receive a CHET screen within 30 days due to untimely notification/documentation of the child/youth's placement in FamLink for follow up. *(Beginning April 2010)*
- ❖ Develop and utilize a management report to monitor performance regarding the length of time between a child's entry into care and documentation of their placement in FamLink. *(By December 31, 2010)*

Strategy 2: Increase Number of Children Provided an Early Periodic Screening Diagnosis and Treatment (EPSDT) Exam within 30 Days of Entry to Care

CA is committed to improving the overall health of children placed in out-of-home care. The initial EPSDT exam is an important practice to help ensure the safety and health of children. The following actions have been identified to increase timely provision of EPSDT exams:

- ❖ Continue to work with the Health and Recovery Services Administration (HRSA) Fostering Well-Being Program to build medical provider capacity to provide EPSDT exams for foster children:
 - HRSA will identify the primary care providers for children in out-of-home care to help target outreach activities. *(June 2010)*
 - CA and HRSA will continue to conduct local outreach activities to identify and work with new medical providers and clinics willing to see foster children for their initial EPSDT and primary care. *(Beginning January 2010)*
- ❖ Assist caregivers, as needed, to identify a medical provider to complete the EPSDT exam within 30 days:
 - HRSA will mail caregivers a child health report based on Medicaid billing within three business days of receiving notification of a child's placement in foster care. This report will help identify a child's primary care physician to maintain continuity of the child's health care when possible. *(Upon program and technical resolution to exclude reproductive health information)*
 - CA will provide staff a list of HRSA Medicaid providers by county, city, and specialty as a resource tool. *(April 2010)*
- ❖ Strengthen communication and information provided to caregivers and social workers about the importance of establishing timely primary health care for children and obtaining initial and ongoing EPSDT exams:
 - Provide information to caregivers through the *Caregiver Connection* newsletter about EPSDT and the new Fostering Well-Being Program. *(May 2010)*
 - Provide information about EPSDT to social workers as part of the April 2010 Policy Roll-Out. *(April 2010)*

- Review current training curriculums for caregivers and staff and work with HRSA to update training material to address the importance of an EPSDT exam when children are initially placed and annually thereafter. *(October 2010)*

(See Attachment 3, Fostering Well Being Program Overview)

(See Attachment 4, Fostering Well Being Program Fact Sheet)

Strategy 3: Increase Timely Receipt of Education Records

CA is committed to improving the educational attainment of children placed in out-of-home care. The Child Health and Education Tracking (CHET) screen helps identify early in placement information about a child's educational needs and services. Educational records must be received and reviewed to complete the Educational domain of the CHET screen. To address timely receipt of education records, a report identifying schools that do not provide timely records will be provided to regions. The regional CHET supervisor in partnership with the regional Education Lead will use the report to target follow up with schools. As needed, the Office of Superintendent of Public Instruction will be consulted to assist in orienting the schools to the statutory records requirement for children in foster care. CA will also explore the possibility of identifying the months of incident to determine the impact of school closure during summer months on completion the Educational domain. *(Regional List of Schools by July 2010, Follow-up by November 2010 and ongoing thereafter)*

Strategy 4: Increase Timely Receipt of Child Health Records

Results of the child's EPSDT exam must be received and reviewed to complete the Physical Health domain of the Child Health & Education Tracking (CHET) screen. To address timely receipt of EPSDT exam results, regional CHET screening teams will identify a list of medical providers that regularly do not provide timely results and triage follow up with the provider. Triage options may include follow up by regional CA staff, the HRSA Regional Medical Consultant, or HRSA as the state Medicaid agency. *(Regional Provider List by September 2010, Follow-up by November 2010)*

CHET SHARED PLANNING MEETING WITHIN 60 DAYS

GOAL 1, OUTCOME 3: A shared planning meeting (SPM) focusing on the CHET screening results will be held within 60 days of each child's entry into care.

Benchmarks Required for Compliance and CA Performance

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	4/17/07	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	Data compliance plan in place			80%	85%	90%
CA Performance*	Data not available for FY09					1/11/11

*Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

CA recognizes timely and thorough planning impacts the needs of children being met. Our goal is to complete a CHET Screen within 30 days for children who are expected to remain in care for 30 days or more and use the results to develop effective case plans. Shared Planning meetings that include the social worker, youth (as applicable), parents, caregivers, and other case participants are held to help develop case plans. CHET screening results are reviewed during the meeting to inform the discussion and plan.

Strategy 1: Strengthen Quality Assurance Review for Child Health & Educational Tracking (CHET)

- ❖ To help ensure CHET screening results are part of the Shared Planning meeting discussion and documented in FamLink, regional CHET supervisors have been designated responsibility to track and ensure this important practice expectation occurs. As technology staff resources permit, a FamLink management report will be developed and implemented to replace regional tracking tool. *(March 2010)*
- ❖ Use the monthly FamLink management report to further analyze regional performance to develop regional improvement action plans and monitor ongoing performance. *(Regional Action Plans developed by July 31, 2010)*

Strategy 2: Strengthen Shared Planning Meeting & CHET Policy and Practice Expectations

Clarify and strengthen policy and practice expectations regarding CA staff roles and responsibilities to address CHET screening results during a Shared Planning meeting within 60 days of a child's entry to care. Areas of practice improvement efforts, include communication regarding staff responsibility to take an active role to ensure CHET screening specialist are invited to the meeting, CHET screening results obtained to-date regardless of overall completion status are addressed during the meeting, CHET reports are provided to social workers and caregivers, meetings are accurately documented in FamLink, and supervisors conduct quality

assurance reviews. (*Memorandum re: Practice Expectations March 2010, Policy Clarification October 2010, Quality Assurance Review beginning March 2010*)

(*See Attachment 5, Memorandum CHET Practice Expectations*)

Strategy 3: Provide In-Service Staff Training on Shared Planning Meetings

Shared planning meetings are held throughout the life of the case to bring families, caregivers, service providers, and the social worker together to develop and implement effective case plans that address the safety, well-being and permanency of children in out of home care. These meetings are fundamental and paramount to the services that Children's Administration provides and the rights of children and families for safe and timely permanency and the needs of children being met while in out of home care. To strengthen our practices related to Shared Planning meetings the following actions have been identified:

- ❖ Provide supervisors and social workers in-person refresher training to review the purpose, value, policy and procedures, roles and responsibilities, and FamLink documentation tips. (*April 2010*)
- ❖ Use FamLink management report to identify, target, and respond to additional local office follow up and training needs. (*Ongoing activity based on performance and beginning upon receipt of FamLink Management Report*)

Strategy 4: Develop and Implement FamLink Management Report

Design, develop, and provide a monthly FamLink management report for CA managers and staff to identify, monitor, and manage CHET Shared Planning meeting practice expectations. Monthly reports will also be provided to the Braam Oversight Panel. (*Beginning June 2010*)

INFANT TODDLER EARLY INTERVENTION PROGRAM (ITEIP)³ REFERRAL WITHIN 2 WORKDAYS

GOAL 1, OUTCOME 4: Children age 3 and under in out-of-home care will be referred to the Infant Toddler Early Intervention Program (ITEIP) within 2 workdays of identification of concerns about developmental delays from their CHET screens.

Benchmarks Required for Compliance and CA Performance

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	4/17/07	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	Data compliance plan in place				85%	90%
CA Performance*	Data not available				72%	1/11/11

*Compliance with this outcome requires the statewide benchmark to be met. In addition, no region’s performance may be more than 10 percentage points lower than the statewide benchmark.

CA is committed to ensuring children receive services responsive to their needs in a timely manner. When the developmental delays of a child are addressed their opportunity for growth and develop are improved.

CA continues to provide children age 3 and under in out-of-home care a referral to the Infant Toddler Early Intervention Program (ITEIP) within 2 workdays of identification of concerns about developmental delays from their CHET screen. CA reached the benchmark statewide for monthly performance in November 2009 at 92% and December at 93%. Achievement of the goal was accomplished through the actions below and some will continue to be the focus for region(s) not reaching the benchmark.

- ❖ A change to the CHET database was made to account for children where there is concern about developmental delay and a referral to ITEIP is not made because the child is already receiving ITEIP services. These occurrences were previously reflected as non-compliant.
- ❖ Regional CHET screening teams completed data clean-up activities to accurately document ITEIP information and referrals in the CHET database.
- ❖ Reminders of policy requirements were provided to CHET supervisors and screening specialists.
- ❖ Monthly review and monitoring of regional and state performance for this outcome occurred and will continue.

(See Attachment 6, November and December 2009 ITEIP Report)

³ During the 2010 Legislative Session, SB 6593 renamed this program to the Early Support for Infant and Toddlers program effective July 1, 2010.

CHILD HEALTH AND EDUCATION UPDATED EVERY 6 MONTHS IN INDIVIDUAL SAFETY AND SERVICE PLAN (ISSP)

GOAL 2, OUTCOME 2: Children in out-of-home care will have health and education plans in their ISSPs updated every 6 months.

Benchmarks Required for Compliance and CA Performance

	CY06	CY07	CY08	CY09	CY10
Monitoring Report Date			3/15/09	3/15/10	3/15/11
Statewide Benchmark	Data Compliance Plan in Place		70%	80%	90%
CA Performance*	Data not available		53%	63%	1/1/11

*Compliance with this outcome requires the statewide benchmark to be met. In addition, no region’s performance may be more than 10 percentage points lower than the statewide benchmark.

CA values thoughtful well developed child health and education plans. Children are growing and changing on a daily basis and children residing in out of home care often experience greater life challenges. Our ability to support healthy outcomes and educational achievement is directly impacted by the depth and quality of information and understanding of the child garnered from the child, family, caregivers, and providers as well as our ability to apply that knowledge through effective case planning and case management.

Strategy 1: Implement Quality Assurance Review for Supervisory Approval of ISSP

CA is committed to meeting the health and education needs of children placed under CA care and supervision. A fundamental practice expectation is to develop and document a child’s health and education plan in the child’s Individual Safety and Service Plan (ISSP). A child’s ISSP is updated at least every six months in conjunction with periodic judicial reviews and requires supervisory review and approval. To better ensure ISSP’s approved by supervisors include an updated health and education plan a quality assurance plan to strengthen the Area Administrators role to provide oversight and accountability will be developed and implemented. *(July 2010)*

Strategy 2: Strengthen Guidance on Documenting a Child’s Health & Education Plan in the ISSP

A Guide for writing the ISSP was created in 2004 to assist staff in developing and documenting a child’s health and education plan and has been updated several times since then. The Guide provides social workers ideas and recommendations regarding what to document in each section of the ISSP. To strengthen information and resources provided to social workers

specifically regarding the health and education section of the ISSP, the following improvement activities have been identified:

- ❖ Continue to implement the new Education Plan document recently published with the February 2010 release of FamLink. The Education Plan simplifies what social workers need to include in the plan by providing built-in fields to address key elements. *(Beginning February 28, 2010)*
- ❖ Provide reminder to social workers and supervisors of the importance for having the child's health and education plan updated in the ISSP along with policy and practice expectations. *(In-Person Training: FamLink Training in February 2010 and Policy Roll-Out Training in April 2010)*
- ❖ Revise the sections of the ISSP Guide regarding the health and education plan for the child with assistance from staff in Region 4, the highest performing region on this outcome. *(May 2010)*
- ❖ Create a quick reference document using information from the ISSP Guide to highlight information about the child/youth's health to include in this section of the ISSP. *(May 2010)*

Strategy 3: Provide Child Health Information by Implementing the Fostering Well-Being Program

Information regarding a child's health is needed to develop and document their health plan. The Health and Recovery Services Administration (HRSA) Fostering Well-Being Program is in the process of being implemented to improve the coordination of health care services for children and includes components to provide more ready and timely access to children's health records. The following program activities address provision of foster children's medical records and health information to caregivers and social workers:

- ❖ The Fostering Well-Being Program is mailing immunization history information to caregivers within three business days of receiving notification of a child's placement in foster care. This information is also documented in FamLink to provide staff ready access. *(January 2010)*
- ❖ HRSA is obtaining and posting in FamLink the last two years of health records for children placed on or after January 1, 2010, and who are in care greater than 30 days. In addition to posting health records in FamLink, HRSA Foster Care Well-Being Program staff are reviewing the records and documenting key information in the child's health pages of FamLink, including physical conditions, disabilities, emotional/behavioral disorders, vision/hearing disorders, brain disorders, and other medical conditions. *(Record collection began February 2010, FamLink data entry beginning May 2010)*
- ❖ HRSA will begin a new practice of developing a Care Coordination Summary for children identified as having the greatest healthcare needs. The goal is to promote effective linkages that will promote continuity and stability in the healthcare needs of the child. CA staff and caregivers will be engaged by HRSA staff to review the summary, action steps, and potential review schedule. The Care Coordination Summary and consultation from HRSA will be used to develop and update the child's health plan included in the ISSP. *(Beginning June 2010, completed for all children in foster care that meet Tier 1 criteria by March 2011)*

UNSAFE & INAPPROPRIATE PLACEMENTS

MEDICALLY FRAGILE CHILDREN

GOAL 1, OUTCOME 5: Medically fragile children will be connected to ongoing and appropriate medical care and placed with caregivers who receive consultation and ongoing training regarding their caretaking responsibilities for the medical condition.

Benchmarks Required for Compliance and CA Performance

	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	10/4/07	9/15/08	9/15/09	9/15/10	7/31/11
Statewide Benchmark	Baseline	85%	90%	95%	95%
CA Performance	74.9%	75.1%	87.6%	83.5%	6/1/11

CA is committed to ensuring children receive services responsive to their needs in a timely manner and takes very seriously the needs of medically fragile children. CA also recognizes caregivers of medically fragile children provide a critical service and have unique and specialized training and support needs.

Strategy 1: Develop and Implement Care Coordination Summary for Medically Fragile Children

The Health and Recovery Systems Administration (HRSA) Fostering Well-Being (FWB) program includes a new practice for the Care Coordination Unit (CCU) to develop a Care Coordination Summary for children identified as having the greatest health care needs. The goal of the Care Coordination Summary is to promote effective linkages that will promote continuity and stability in the healthcare needs of the child. Medically fragile children are included in the population referred to as Level 1 that receives highest priority for development of a Care Coordination Summary. A Level 1 Care Coordination Summary will include:

- Pertinent medical information contained in the referral form, CHET Screening Report, PRISM, FamLink, and available medical records
- Identification of health concerns and gaps in healthcare services, including substance abuse and mental health concerns
- EPSDT exam results
- Identification of child's most recent health provider(s)
- Action steps for the child's social worker and caregiver to address identified gaps in healthcare

The FWB CCU Nursing Care Advisors will contact the child's social worker, caregiver and the Regional Medical Consultant to ensure all parties are aware of the medically fragile child's needs and the plan to address their medical needs. If it appears the system of care for the child

needs improvement, a conference call with all parties will be convened by the CCU. Depending on the needs of each child, their Care Coordination Summary may include a review schedule for parties to regularly touch base regarding the medical care, status, and needs of the medically fragile child.

Once healthcare linkages have been established and the child's health care needs are stable, the child may be moved to a lower level of care coordination. If at any time the child's health becomes unstable, they may be escalated back to Level 1.

(Beginning April 2010, completed for applicable Medically Fragile foster children that meet Tier 1 criteria by October 2010)

(See Attachment 7, Fostering Well Being Care Coordination Unit Fact Sheet)

Strategy 2: Develop and Implement Caregiver Support Plan for Medically Fragile Children

Caregivers of medically fragile children have unique and special support needs pertaining, but not limited to their need to access medical consultation, receive information and training for the child's medical condition and their caretaking responsibilities, obtain prescribed medication and medical supplies, access supports and respite to maintain and promote personal and family well-being. Social workers are responsible for consulting with the child's caregiver regarding any needs they may have for additional training or supports. As HRSA develops Care Coordination Summaries, they can be used to inform the discussion with the caregiver. Policy and procedures for Caregiver Support Plans will be formalized statewide in April 2011. In the interim a practice expectation will be communicated to staff and monitored for caregivers of medically fragile children through the Medically Fragile Quality Assurance Plan. *(Practice Expectation for Medically Fragile completed in July 2010)*

See description for Strategy 1 under [Placement Stability](#) (click on link)

Strategy 3: Develop and Implement a Medically Fragile Quality Assurance Plan

CA will collaborate with HRSA to develop and implement a Quality Assurance Plan to clarify, strengthen, and monitor practice expectations for medically fragile children. *(August 2010)*

The quality assurance plan will address the following items to ensure medically fragile children:

- Receive appropriate medical care
- Are placed with caregivers that receive consultation, ongoing training, and support regarding their caretaking responsibilities
- Are placed with caregivers that report satisfaction with the level of support they receive
- Are accurately identified as medically fragile, based on the established definition used by HRSA, CA social workers and CHET Screen specialists
- Are appropriately identified as medically fragile in FamLink

MONTHLY VISITS

GOAL 1, OUTCOME 6: Children will receive a private and individual face-to-face health and safety visit from an assigned caseworker at least once every calendar month, with no visit being more than 40 days after the previous visit.

Benchmarks Required for Compliance and CA Performance

	FY05	CY06	CY07	FY08	FY09	FY10
Monitoring Report Date	10/4/07	10/4/07	9/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark*	Baseline	75%	85%	95%	95%	95%
CA Performance	Data not available	8/1/07	43.2% FP Survey	10.5% Admin Data	14.8% Admin Data	1/1/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

CA is committed to continued improvement conducting individual face-to-face health and safety visits with children in our care. Conducting monthly visits with children in foster care is a critical component of child welfare system procedures for ensuring the safety of children and the wellbeing of families. When we do well on monthly visits we are better positioned to assess children's safety and risk and need for alternative permanency options, to identify and provide services that are needed and to engage children and parents in planning their future.

Strategy 1: Reduce Timeline to Document Monthly Visits in FamLink and Clarify Policy and FamLink Documentation Requirements

- ❖ Reduce amount of time social workers have to document their monthly health and safety visit with children in FamLink from 30 days to 7 calendar days. *(April 2010)*
- ❖ Provide social workers and supervisor's clarification and reminder monthly visits are required every calendar month per policy and not to exceed 40 days between visits through in-person policy roll-out training and policy update materials posted on the CA intranet. *(April 2010)*
- ❖ Provide social workers and supervisors a quick reference desk aide that identifies requirements for health and safety visits that identifies for each case type the frequency, location, FamLink documentation codes, and policy reference. *(April 2010)*

Strategy 2: Strengthen Quality Assurance Review & Improvement Activities

The following actions have been identified to strengthen performance on monthly visits:

- ❖ Area Administrators will monitor performance and supervisor/social worker planning and scheduling activities to reinforce the priority of monthly visits with children and accountability of the supervisor and social worker to meet this policy requirement. *(Statewide April 2010)*
- ❖ Monthly email communication will be sent showing regional and office performance. *(Statewide April 2010)*
- ❖ A monthly list of children/youth identified as not having been seen will be provided to Area Administrators for follow up with supervisors and social workers to ensure visits occur, are documented, and/or FamLink data integrity issue identified and corrected. *(Statewide April 2010)*
- ❖ CA Leadership will follow up with low performing regions, offices, units, and staff to identify and problem-solve practice improvement issues and needs. *(Statewide April 2010)*
- ❖ Statewide Program Evaluation Managers will monitor performance and support practice improvement by following up with regions and providing performance updates to leadership. *(August 2010)*

Strategy 3: Decrease Social Worker Caseload by Focusing on Timely Permanency

See description for strategies under [caseloads at or below 18 cases](#) (click on link)

(See Attachment 8, January 2010 Monthly Visit Performance)

(See Attachment 9, Policy Summary – Documentation Timeframes Effective 4/30/10)

(See Attachment 10, Desk AID – Monthly Health and Safety Visits)

Victims of Child Abuse and/or Neglect by Licensed Foster Parent or Facility Staff

GOAL 2, OUTCOME 1: The percentage of children who are not victims of a founded report of child abuse or neglect by a foster parent or facility staff member will meet or exceed the federal Child and Family Services Review (round 2) standard.

Benchmarks Required for Compliance and CA Performance

	FY07	FY08	FY09	FY10
Monitoring Report Date	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark*	99.68%	99.68%	99.68%	99.68%
CA Performance	99.57%	99.77%	99.62%	1/1/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

Strategy 1: Analyze FY2009 Maltreatment Findings of Child Abuse and/or Neglect

CA is committed to ensuring children and youth are safe from abuse and neglect in out-of-home care. CA will review the investigations of the 66 victims of child abuse and/or neglect by a licensed foster parent or facility staff member during FY2009. The review will include identifying themes, patterns, and lessons learned for practice and system improvement. Consultation will also occur with the Office of the Family and Children's Ombudsman to determine if they have identified any indicators, patterns, and recommendations. DLR will share a summary of findings and recommendations with the Statewide Quality Assurance Team and CA Leadership team and develop and implement an action plan as needed. (*Summary of Findings, September 2010*)

Strategy 2: Provide Social Workers Information and Training on Licensing Violations

CA is committed to helping address and resolve issues in licensed foster homes and or facilities as soon as they are identified. Early identification of licensing issues reduces the risk of harm to children. To help DLR licensors identify concerns earlier, CA will provide additional training for social workers about when to call intake about licensing concerns. Training will include what to look for during home visits, how to make a licensing intake, and why it is important to report licensing concerns. CA will take the following actions to encourage early reporting of licensing violations:

- ❖ Issue a memorandum to all-staff providing information regarding when to call intake about licensing concerns. (*May 2010*)
- ❖ Provide in-person training to Child and Family Welfare Services (CFWS) social workers on what to look for during home visits, when to call intake about licensing concerns, and why it is important to report licensing concerns as soon as possible. Include information, findings,

and recommendations from analysis of maltreatment findings of child abuse and/or neglect and information from consultation with the Ombudsman. *(Begin by August 2010 and completed by October 2010)*

- ❖ Assess feasibility of revising Academy training curriculum to improve training for new social workers about reporting licensing concerns. *(June 2010)*

DIVISION OF LICENSED RESOURCES (DLR) CHILD PROTECTIVE SERVICE (CPS) INVESTIGATION

GOAL 2, OUTCOME 2: All referrals alleging child abuse and neglect of children in out-of-home care will receive thorough investigation by the Division of Licensing Resources (DLR) pursuant to CA policy and timeline and with required documentation.

Benchmarks Required for Compliance and CA Performance

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	4/17/07	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark*	Data compliance plan in place		100%	100%	100%	100%
CA Performance	Data not available		87%	90.9%	82.9%	1/1/11

* Because the benchmark is 100%, there is no specific rule for regional variation, as long as the statewide benchmark is reached. Data is gathered through a case review process. Two questions were added to the case review measure in 2010 and led to a decrease in performance from previous fiscal years.

Strategy 1: Increase Timely Initial Face to Face (IFF) Contacts with Alleged Victims of Child Abuse and Neglect

CA is committed to seeing and interviewing (verbal) alleged victims of alleged child abuse and neglect within 24 hours for emergent intakes and 72 hours for non-emergent intakes. To improve DLR/CPS performance on timely Initial Face to Face (IFF) contacts with alleged victims of CA/N, supervisors will use weekly management reports to identify practice issues and address documentation errors contributing to non-compliance. *(Beginning March 2010)*

Strategy 2: Implement Quality Assurance Review for IFF Exceptions and Extensions

Social workers can request approval for extensions or exceptions to the IFF policy in limited circumstances when the extension or exception will not impact child safety. DLR Area Administrators will conduct monthly quality assurance reviews of IFF extensions and exceptions approved by DLR/CPS supervisors. *(April 2010)*

The quality assurance review will include:

- 100% of exceptions
- All extensions of emergent intakes where the IFF does not occur within 72 hours
- All extensions of non-emergent intakes where the IFF does not occur within 5 days (120 hours)

Strategy 3: Strengthen the Quality of Safety Plans

CA is taking steps to strengthen the quality of Safety Plans developed by social workers by instituting regional oversight to review and approve all safety plans. CA has requested technical assistance from the National Resource Center for Child Protection to develop and provide training for supervisors and managers about conducting safety assessments, and developing and monitoring safety plans. DLR will improve the quality of DLR/ CPS Safety Plans through the following actions:

- ❖ Continue requiring the statewide DLR/CPS program Manager to review and approve all Safety Plans. *(Beginning December 2009)*
- ❖ Continue requiring the DLR Administrator to review and approve all Safety Plans that involve the perpetrator leaving the home. *(Beginning December 2009)*
- ❖ Participate in the development of the Safety Assessment and Safety Plan training with the National Resource Center for Child Protection. *(August 2010)*
- ❖ Provide training for Safety Assessment and Safety planning developed with the National Resource Center for Child Protection to DLR/CPS staff. *(By December 2010)*

Strategy 4: Ensure Timely Case Closure of DLR Child Protective Service (CPS) Investigations

CA is committed to providing timely CPS investigations and closing DLR-CPS cases within 90 days, unless the involvement of law enforcement or the prosecuting attorney's office warrants an extension. To ensure DLR/CPS cases are completed within the 90-day timeframe, each month the DLR/CPS program manager will provide each DLR/CPS Supervisor and DLR Area Administrator a list of cases open over 60 days for review and follow up. If law enforcement or the prosecuting attorneys' office involvement in the investigation requires a case to remain open over 90 days, the supervisor will ensure ongoing communication with law enforcement occurs and is documented in FamLink. *(April 2010)*

SIBLING SEPARATION

ALL SIBLINGS PLACED TOGETHER AND SIBLINGS PLACED WITH AT LEAST ONE SIBLING

GOAL 1, OUTCOME 1: Children in out-of-home care will be placed with all siblings who are also in out-of-home care whenever possible.

Benchmarks Required for Compliance and CA Performance – Outcome 1

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	-	4/17/07	7/15/08	3/15/09	3/15/10	3/31/11
Statewide Benchmark	-	Baseline	60%	65%	70%	75%
CA Performance	59.6%	58.9%	58.3%	56.7%	60.9%	1/01/11

GOAL 1, OUTCOME 2: Children in out-of-home care will be placed with at least one sibling who is also in out-of-home care whenever possible.

Benchmarks Required for Compliance and CA Performance – Outcome 2

	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	7/15/08	3/15/09	3/15/10	3/31/11
Statewide Benchmark	Baseline	85%	90%	90%	90%
CA Performance	80.1%	79.3%	79%	80.9%	1/01/11

CA is committed to keeping children together with their sisters and brothers whenever possible. Relationships with siblings are fundamentally important over a lifetime. Living together supports the likelihood of a strong and positive bond, increases placement stability, and helps prevent additional grief and loss.

Strategy 1: Develop and Implement Placement Coordinator Protocol, Guidelines and Training

Convene a statewide workgroup comprised of CA staff and representatives from birth parents, youth, private agencies, and caregiver organizations to develop a standard statewide protocol, guidelines, and training for Placement Coordinators and staff matching children with licensed placement resources. The purpose is to strengthen and promote the quality, consistency, and outcomes of placement decisions to better preserve and promote a child's connections to family, siblings, and their community. The statewide workgroup will develop the following:

- ❖ Standard placement protocol that will be used statewide by Placement Coordinators and staff matching children with licensed placement resources. The protocol will address decision-making that supports the quality and consistency of selecting placement resources that preserve and promote a child's connections to family, siblings, and their community and the order of priority when considering factors that influence placement selection. The protocol will include steps to maximize the use of licensed caregiver resources for sibling groups and identify minimum practice expectations to be completed prior to requesting a licensed out of home placement resource (e.g. FTDM, Relative Search, etc).
- ❖ Training curriculum, materials, and implementation plan to provide Placement Coordinator and staff matching children with licensed placement resources training on the following:
 - How to use the FamLink Placement Vacancy Report to identify capacity/availability of licensed foster homes.
 - How to use FamLink to identify and match caregiver preferences with characteristics of children/youth.
 - Caregiver considerations, including the need to carefully consider commitment to sibling groups, location, individual attributes, strengths and needs, family constellation, and ability to meet long term needs.
- ❖ Additional recommendations for CA Leadership Team consideration regarding placement decisions to promote placement stability, sibling relationships, sibling and family connections, etc.

(Protocol & Guidelines, August 2010; Training, November 2010)

Strategy 2: Revise Family Team Decision Meeting Protocol and Facilitator Training

Review and update Family Team Decision Meeting (FTDM) protocol and meeting facilitator training to dedicate part of the meeting, when sibling groups are to be placed in out of home care, to a discussion that addresses the value of siblings living together whenever appropriate and possible and when they cannot be placed together the need for ongoing visits and contact to maintain their connection. *(August 2010)*

Strategy 3: Develop and Implement Caregiver Support Plan

See description for Strategy 1 under [Placement Stability](#) (click on link)

Strategy 4: Enhance Focus on Timely Permanency for Children Residing with Relatives

See description for Strategy 3 under [Placement Stability](#) (click on link)

Strategy 5: Assess Need for Additional Foster Parent Resource Development Strategies

See description for Strategy 4 under [Placement Stability](#) (click on link)

Strategy 6: Seek Technical Assistance from the National Resource Center for Permanency and Family Connections at Hunter College

CA will include sibling placements in our request for national consultation and technical assistance to identify strategies, tools, resources and recommendations based on what is working well in other states to improve practice in placing siblings together and maintaining connections when siblings are not placed together. *(May 2010)*

SERVICES TO ADOLESCENTS

HIGH SCHOOL GRADUATION FOR YOUTH IN 9TH GRADE THAT REMAIN IN CARE UNTIL 12TH GRADE

GOAL 2, OUTCOME 2: The percentage of youth in out-of-home placement in grade 9 who remained in placement continuously through grade 12 who graduate from high school on time with a regular or adult (IEP) diploma, including students with disabilities who graduated within the number of years designated in their IEP, will increase as indicated in the benchmark table below.

Benchmarks Required for Compliance and CA Performance

	FY07	FY08	FY09	FY10
Monitoring Report Date	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark	Baseline	50%	60%	70%
CA Performance*	7/1/08	1/1/09	48%	1/1/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

CA remains committed to increasing the opportunities and supports for children in foster care to increase their achievement of successful educational outcomes.

Strategy 1: Increase Youth Engagement in Case Planning Activities

In collaboration with the newly forming Statewide Social Worker and Supervisor Advisory Committee, foster youth advisory committees, and statewide relative and foster parent committees identify and share recommendations with staff to increase youth involvement in their case planning activities, including the development and implementation of their education plan. *(August 2010)*

Strategy 2: Continue to Obtain, Review, and Strengthen Interagency Agreements with School Districts

CA will continue to work with school districts, targeting districts with more than 50 students in foster care, to ensure interagency agreements for the purpose of promoting educational stability for children in foster care are in place, being implemented, and reviewed a minimum of every two years. Strategic efforts include:

- ❖ Establish Interagency Agreements with the remaining 18 of 91 school districts with identified high rates of removal. When agreements are in place with these 91 school districts over 90% of the youth in foster care will be covered by an agreement. *(December 2010)*

- ❖ Continue efforts to establish agreements with the remaining 113 of 295 school districts in the state prioritizing school districts where foster children are attending school. *(June 2011)*
- ❖ Review and strengthen signed interagency school district agreements (182 agreements and growing) through consultation with the statewide 1058 Foster Care Educational Oversight Committee. Discussion will include expanding the purpose of the agreement beyond promoting educational stability for children in foster to include educational achievement and amending any pertinent sections in the agreement template. Recommended changes will be incorporated into new agreements and when existing agreements are reviewed and updated. School districts where foster children are attending school will be prioritized. *(Ongoing)*

(See Attachment 11, April 2010 School District/CA MOU Update)

(See Attachment 12, Example of Interagency Agreement between CA and School District)

Strategy 3: Continue to Strengthen Educational Partnerships

Continue to partner with Treehouse, Local School Districts, and the Office of Superintendent for Public Instruction (OSPI) as applicable to:

- ❖ Provide social workers and existing caregivers the package of information the Resource Family Training Institute (RFTI) currently provides to new foster parents. Include in the package the Social Workers Practice Guide to Education and The Educational Advocacy Guide for Caregivers. *(August 2010)*
- ❖ Increase staff and caregiver awareness of where to access educational resource information for youth, including tutors, by posting information on the CA intranet and Resource Family website and publishing information in the *Caregiver Connections* newsletter and the new e-newsletter for CA staff. *(September 2010)*
- ❖ Provide social workers and contracted Independent Living providers a list of foster children between 14-18 years to help connect youth to high school completion, career, and college prep programs. Increase staff and caregiver awareness of career and college bound programs through on-line and newsletter communication. Programs may include but are not limited to the GEAR UP program administered by the Higher Education Coordinating Board (<http://www.gearup.wa.gov/>) (click on link) and the Supplemental Educational Transition Planning (SET UP) program that provides comprehensive information and support regarding postsecondary educational opportunities for youth 14-18 years old in every region. *(By November 2010)*
- ❖ Increase use of the Treehouse Advocacy Program to focus on education credit retrieval and partnerships with adolescent foster youth to stay on track to graduate by providing social workers additional information and encouragement to make Treehouse referrals for adolescents experiencing challenges as Treehouse has a specialized focus on serving older adolescents. *(April 2010)*

Strategy 4: Examine High School Graduation Data and Identify & Implement Improvement Strategies

Utilize the Education Workgroup to examine information related to foster youth's attendance, truancy, suspensions, and expulsions to include a review of practice and factors influencing high school graduation performance. The workgroup will address the relationship of high school graduation to school district performance and identify successful practices that might be replicated to improve educational attainment of foster youth, including strategies that focus on early identification and academic support prior to students entering high school. The workgroup will obtain input from the Passion to Action and Mockingbird foster youth advisory committees and collaborate with the 1058 Education Oversight Committee. *(First Meeting Held by May 2010, Recommendations presented to CA Leadership by October 2010)*

See strategies included for [Placement Stability](#) (click on link) and [Health & Education Plans](#) (click on link).

YOUTH TRANSITION STAFFING SIX MONTHS PRIOR TO EXIT FROM FOSTER CARE

GOAL 2, OUTCOME 3: A multi-disciplinary staffing meeting will be held six months prior to a youth's exit from foster care to address issues related to transition to independence.

Benchmarks Required for Compliance and CA Performance

	CY07	CY08	CY09	CY10
Monitoring Report Date	9/15/08	9/15/09	9/15/10	7/31/11
Statewide Benchmark	Baseline	75%	85%	95%
CA Performance*	Data not available			

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 10 percentage points lower than the statewide benchmark.

CA is dedicated to helping youth have a successful transition into adulthood. Whatever path they walk it will be a path full of anticipated and unanticipated challenges. Children who enter adult life from foster care face greater risks than many of their peers. CA recognizes the importance of engaging and supporting youth in planning for the transition and their future. Effective transition planning requires collaboration, youth engagement, thoughtful communication, guidance and support to encourage excitement and a foundation for the youth's success in their next stage of their life.

Strategy 1: Provide Regional List of Youth Turning 17 Years

Provide regions monthly list of foster youth turning 17 years old with a reminder to schedule an Exit Staffing involving the youth, caregiver, service providers, and other important people in the youth's life to discuss and plan for the youth's transition to independence, including development of a Transition Plan. *(Beginning June 2010)*

Strategy 2: Change Time of Automatic FamLink Email to When Youth Turns 17 Years

Submit FamLink design change request to modify current FamLink email notification that is sent to social workers to alert them when a youth turns 17.5 years to 17 years. *(May 2010)*

Strategy 3: Implement Quality Assurance Review

Develop and implement monthly quality assurance review by designated Statewide Program Manager to monitor the quality and compliance of this practice expectation. *(June 2010)*

Strategy 4: Develop and Implement Standardized Transition Plan Form

Develop and implement a standardized form to document the Transition Plan during the Shared Planning meeting. *(Developed by July 2010, Implemented Statewide October 2010)*

FREQUENCY OF CHILDREN RUNNING FROM CARE AND MEDIAN DAYS OF CHILDREN ON RUN STATUS

GOAL 3, OUTCOME 1: The percentage of children who run from out-of-home care placements during the fiscal year will decrease as indicated in the benchmark table below.

Benchmarks Required for Compliance and CA Performance – Outcome 1

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	4/17/07	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark*	Baseline	4.0%	3.5%	3.0%	2.5%	2.0%
CA Performance	4.0%	4.1%	4.1%	3.6%	3.4%	1/11/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than .5 percentage points higher than the statewide benchmark.

GOAL 3, OUTCOME 2: The median number of days that children are on runaway status will decrease as indicated in the benchmark table below.

Benchmarks Required for Compliance and CA Performance – Outcome 2

	FY05	FY06	FY07	FY08	FY09	FY10
Monitoring Report Date	4/17/07	4/17/07	7/15/08	3/15/09	3/15/10	3/15/11
Statewide Benchmark*	Baseline	45 days	40 days	35 days	30 days	25 days
CA Performance	43	42	39	33	27	1/1/11

* Compliance with this outcome requires the statewide benchmark to be met. In addition, no region's performance may be more than 5 days higher than the statewide benchmark.

CA recognizes the very serious safety threats to youth on the run and remains committed to a continued decrease in the number of youth runaways and the number of days youth are on runaway status by continuing to build on the following successful practices.

Strategy 1: Continue to Implement Monthly Quality Assurance Review

Continue to strengthen quality assurance review activities required per policy. These activities include regional and statewide monthly review of children/youth missing from care to monitor and report adherence to policy requirements, including notification and collaboration with law

enforcement, active efforts to locate and engage children/youth, and staffings held to identify and address safety and stability. Additional attention will be focused on Region 5 to better understand regional differences and challenges and strengthen policy and quality assurance review requirements. *(Ongoing)*

Strategy 2: Increase Youth Engagement in Case Planning Activities

In collaboration with the newly forming Statewide Social Worker and Supervisor Advisory Committee, foster youth advisory committees, and statewide relative and foster parent consultation committees identify and share recommendations to increase youth involvement in case planning activities, including the development and implementation of their education plan. *(August 2010)*

Strategy 3: Strengthen Outreach and Partnerships with Local Youth Service Programs and Shelters

Increase outreach and strengthen partnerships with local youth services and shelters to strengthen communication, relationship, and shared talking points for talking with youth to encourage them to contact their social worker, understand CA is working in their (the youth's) best interest, and the benefit of communicating and helping problem-solve their concerns (reason(s) they are on the run), including identification of a possible placement resource. *(Initial Contacts by August 2010)*

FOUNDATIONAL STRATEGIES

In addition to the specific improvement strategies identified for each outcome, seven foundational strategies are included in the following pages of the report. These strategies are foundational in nature and encompass strategic areas of CA focus with broad impact. While these strategies are fundamental in nature, they are included at the end of the report to bring to the forefront the particular practice improvement strategies that are specific to each outcome and avoid replication under each outcome area they impact.

INCREASE FREQUENCY & EFFECTIVENESS OF FAMILY TEAM DECISION MAKING MEETINGS

The goal of Family Team Decision Meetings (FTDM) is to involve birth families and community members along with resource families, service providers and agency staff, in all placement decisions to ensure a network of support for the child and the adults who care for them. Participants include formal and informal supports.

The values of Family Team Decision Meetings reflect the beliefs that:

- Every child deserves a family
- Every family needs the support of the community
- Public child welfare agencies need community partners
- A group can be more effective in decision making than an individual
- Families are the experts on themselves
- When families are respectfully included in the decision making process they are capable of identifying and participating in addressing their needs
- Members of the family's own community add value to the process by serving as natural allies to the family and experts on the community's resources.

The following actions have been identified to (a) engage families and community members, along with resource families, service providers and agency staff, in developing safety plans, making placement decisions, and preserving placements when it is safe for the child and (b) increase the effective use of Family Team Decision Meetings as a vehicle to safe permanency and well-being for children:

- ❖ Review and assess statewide *practices* for FTDM's and determine training and support needs and policy requirements to improve quality of practices and how they can be used to better impact timely and safe permanency. (*October 2010*)
- ❖ Update FTDM *policy and protocol*, including record keeping, to support increased consistency and quality of practice. (*Protocol September 2010, Policy Revised April 2011*)
- ❖ Create a *supervision structure* for meeting facilitators which includes regular observations and feedback by managers trained on the FTDM practice model. (*August 2010*)
- ❖ Assess effectiveness of current FTDM *facilitator training* curriculum and identify strategies and resources for improvements to initial and ongoing facilitator training, including potential inclusion in Academy. (*October 2010*)

- ❖ Review and analyze existing FTDM structures and practices to identify methods to increase *community participation*. Recommendations will be provided to CA Leadership for consideration. (*October 2010*)
- ❖ Develop and utilize a *management report* to ensure family team decision meetings are scheduled and convened for families according to CA requirements and timelines. (*By December 31, 2010*)

INTEGRATE THE PRACTICE MODEL SOLUTION-BASED CASEWORK INTO THE WAY WE DO BUSINESS

The CA Practice Model, which is based on the tenets of Solution-Based Casework (SBC), provides a framework for social workers to focus their day-to-day work with children and families. SBC is a family-centered practice model of child welfare assessment, case planning, and ongoing case work. The model targets specific everyday events in the life that have caused the family difficulty and led to a lack of child safety. SBC combines the best of problem focused relapse prevention approaches with solutions and family systems therapy and casework. Social workers have been taught engagement skills that lead to partnerships for safety, importance for focusing on pragmatic everyday life tasks, relapse prevention skills and development of case plans that center on specific prevention skills tied to the family's tasks.

As of January 2010, DCFS and DLR staff have been trained in SBC. In the coming year, additional activities are planned to sustain change and support integration of SBC into practice:

Reinforce Child Safety through SBC

- ❖ Review and edit all SBC training materials, forms, documents, and tip sheets used by the practice model team to ensure they are in concert with a child safety focus. (*Internal Review April 2010, External Review August 2010*)
- ❖ Strengthen social worker understanding that SBC best practice is centered on child safety by developing and providing advanced workshops to supervisors. These workshops will provide an opportunity for professional development and acquisition of advanced skills in SBC. (*Curriculum August 2010, Supervisor Training Completed April 2011*)

Provide and Integrate Case Consultations into Practice

- ❖ Develop and implement a statewide protocol to formalize and reinforce case consultations as a standard of practice. (*August 2010*)
- ❖ SBC Coaches facilitate case consultations for social work teams (units) statewide with goal to facilitate a minimum of three consultations for every case carrying unit in the state. (*In Process, Goal completed by September 2010*).
- ❖ Teach and support supervisors on the SBC case consultation model and how to facilitate case consultations. (*Completed Statewide December 2010*)
- ❖ Identify SBC Site Consultants for local offices and provide one day training and ongoing support to prepare these staff to facilitate case consultations and be a SBC champion. (*Site Consultants identified by May 2010, Initial Orientation by June 2010, Training by September 2010*)

Provide Education and Training

- ❖ Revise and strengthen the Academy training curriculum for social workers and supervisors on SBC and implement a co-training model using a practice model coach. (*Beginning April 2010, Completed August 2010*)
- ❖ In partnership with the Court Improvement Training Academy (CITA) and Partners for Our Children (POC) develop and implement 4-hour SBC training for judicial staff. (*est. 10*)

counties provided training by July 2010, Training plan recommendations for remaining counties by October 2010).

- ❖ Provide Washington State Tribal social service staff training in SBC. To-date, the Quinault Nation and the Spokane Tribe received SBC training. *(Upon Request)*

Integrate SBC Practice Model

The Practice Model Coaching team is working throughout the administration to identify and leverage opportunities to integrate SBC and strengthen their role as practice consultants.

Examples of some of the integration activities include but are not limited to:

- ❖ Use lessons learned from internal and external reviews in case consultation. *(Starting March 2010)*
- ❖ Develop and provide advanced SBC training to teach managers how to administer the practice model within their scope of responsibility. *(Curriculum by September 2010, Training provided by December 2010)*
- ❖ Incorporate SBC practice expectations in Position Description Forms (PDF) for social workers and supervisors. *(In process, completed by August 2010)*
- ❖ Include SBC practice expectations and professional development plan in annual employee Performance and Development Plans (PDP) for social workers and supervisors. *(Supervisors beginning Year 2011, Social Workers beginning Year 2012)*

ENHANCE AND INCREASE CAPACITY FOR QUALITY ASSURANCE AND CONTINUOUS QUALITY IMPROVEMENT

The Children's Administration is committed to providing quality services and improving outcomes for the children and families we serve. Quality assurance (QA) and continuous quality improvement (CQI) systems are essential mechanisms to achieve our goals.

QA and CQI improve the quality, efficiency and effectiveness of the way we do business in accordance with our core values by emphasizing:

- ❖ *Data Driven Decisions:* Benchmarks are established in the areas of child safety, permanency, and child and family well-being and performance is measured on a regular basis. Findings from research and promising practices inform decision-making.
- ❖ *Quality Management:* The success of CA managers, staff, and work units is regularly measured against improvements in quality results. A system of accountability is used wherein staff at all levels of the organization have a role in assuring that services are provided to the children and families CA serves in compliance with policy and statute.
- ❖ *Customer Defined Services:* Within legislative and budget parameters, child and family needs determine services arranged or provided. Recipients of CA services are regularly surveyed to measure the accessibility and usefulness of services and the responsiveness and effectiveness of agency staff.
- ❖ *Staff, Partner, Tribe, and Provider Involvement:* CA engages in an open, inclusive, information-based decision-making process where individuals involved in the child welfare system are afforded the opportunity to contribute to decision in areas of expertise.

CA is in the process of strengthening and building capacity of our QA and CQI systems, in a number of areas, including but not limited to:

- Processes to support continuous quality improvement
- Increased accountability, including clearer and stronger expectations and evaluation
- Development and use of communication and feedback systems
- Use of case consultation as a standard of practice
- Development and use of Program Evaluation Manager positions to provide evaluation and monitoring of program areas to determine compliance with CA policy and procedures and quality of practice
- Identification and utilization of lessons learned to inform and improve practice
- Improvements to statewide and regional quality assurance reviews

Highlights of some of the QA and CQI priority activities in 2010:

- ❖ Enhance protocols to strengthen our practice for reporting, reviewing, and responding to Critical Incidents. (*Beginning December 2009*)
- ❖ Establish a statewide team of standing internal staff and rotating external participants to review and identify recommendations for high profile critical incidents. (*Team identified June 2010, Training by August 2010*)

- ❖ Continue development and use of FamLink Utilization Audit Reports to inform managers of staff's use of FamLink in key practice areas, including validation and refinement to achieve confidence in accuracy of reports. *(Beginning January 2010, Key reports developed by January 2011)*
- ❖ Increase expectation and support for supervisors and managers to use FamLink to monitor and review staff compliance with key policy and practice expectations. *(Beginning September 2009, Position Description Forms updated August 2010)*
- ❖ Establish and implement new full-time Program Evaluation Manager (PEM) positions, through reassignment, to provide third party program evaluation functions including monitoring and analysis of program areas and outcomes to determine compliance with CA policy and procedures and quality of practice. *(Position Description Form (PDF) approved by Human Resources by June 2010, Positions filled through reassignment by July/August 2010, In-service Training by September 2010)*
- ❖ Increase responsibility for statewide program managers to perform quality assurance functions. *(Beginning February 2010)*
- ❖ Strengthen and formalize practice of providing managers, supervisors, and social workers findings from reviews and recommendations on which to build and strengthen social work practice; along with review and follow up of actions to ensure recommendations are being implemented. *(Beginning February 2010)*
- ❖ Develop and facilitate Statewide Quality Assurance & Improvement Team to provide input and assistance with CQI activities, including development and implementation of Braam Settlement Agreement compliance plans and recommendations for CA Leadership consideration regarding findings from internal and external reviews. *(Beginning January 2010)*
- ❖ Develop and facilitate Statewide Advisory Committee consisting of CA social workers and supervisors to provide input and assistance with CQI activities, draft policies and procedures, professional development ideas and needs, and organizational improvement. *(Beginning April 2010)*
- ❖ Develop and implement topic-specific quality assurance plans to target oversight and management of critical practice areas, including Safety Plans, Sexually Aggressive Youth (SAY) and Physically Assaultive and Aggressive Youth (PAAY) and medically fragile children/youth. *(Beginning December 2009)*

STRENGTHEN CLINICAL SUPERVISION

Supervisors perform a critical role in CA. Social Work Supervisors have responsibility for the administration, clinical education, oversight and support of social worker staff having the greatest impact on children and families. We depend on Social Work Supervisors to promote and maintain required standards of work and to assess the capabilities of social workers in order to build on strengths and motivate professional learning, growth and development.

Social Work Supervisors are leaders, teachers, and evaluators with significant responsibility for the quality of services and outcomes.

Clinical Supervision is the process in which supervisors impart knowledge, values, and skills of CA's practice model. It is a vehicle that helps social workers develop skills and attitudes that will enhance their work and improved outcomes for children and families. When clinical supervision is effective social workers feel supported, valued and able to continue their work.

To provide clinical supervision, supervisors must be competent and able to provide social workers guidance, instruction, and support. CA is committed to strengthening the skills and competencies of Social Work Supervisors to provide clinical supervision through the following activities:

- ❖ With on-site technical assistance from the National Resource Center for Child Protection provide training for all supervisors and managers on child safety assessments, developing and monitoring comprehensive safety plans, and conducting case staffings. (*Curriculum development August 2010, Training provided by December 2010*)
- ❖ Implement Grand Rounds as a standard of practice; a case consultation model from the medical field where staff present a case to a team of peers and professionals to examine and bring ideas from every perspective together to help build an effective intervention/case plan. A protocol will be developed and implemented in partnership with supervisors and managers. (*September 2010*)
- ❖ In partnership with the University of Washington, School of Social Work strengthen existing supervisor training curriculum and develop and provide additional training for social work supervisors on clinical supervision. (*Curriculum by December 2010, Training April 2011*)
- ❖ Increase professional training opportunities for social work supervisors and managers, including greater accessibility to existing trainings. For example, the collaborative project with the University of Washington Endowed Professor Lecture Series that brings the lecture series to CA staff by recording and presenting it with facilitation in regional offices. Some of the upcoming topics of the Lectures include "Engaging Parents in Child Welfare Services" and "Reuniting Families in Washington State." (*Beginning April 2010*)
- ❖ Continue to develop supervisor's knowledge, skills, and abilities in Solution-Based Casework and Solution Focused Management and implications for day-to-day practice. See *foundational strategy for [Solution Based Casework](#)* (click on link)
- ❖ Establish a Statewide Advisory Committee consisting of CA social workers and supervisors to assist with development, implementation, and assessment of strategies to strengthen clinical supervision, in addition to other CQI activities. (*Beginning April 2010*)

INSTITUTE A LEARNING ENVIRONMENT WITHIN THE CHILDREN'S ADMINISTRATION

A learning organization is one that values continuing learning and implements practices that promote, invite, support, and require ongoing professional growth and development of staff. Learning that is both self and group initiated. A learning environment is recognized by having staff that embrace learning, are open with others, understand and are committed to our work, and seek out in partnership with others achievement of our mission.

The Department of Social and Health Services has committed to One DSHS Vision, Mission and a Core Set of Values. The actions identified by DSHS to support high-performing programs in an integrated organization, includes becoming a learning organization through continuous learning and professional growth. CA is committed to taking the necessary steps to integrate the value of continual learning throughout the workplace.

Child welfare work is intense and fast paced and must be responsive to many and varied partners. The work environment is one in which change is an expected condition. The needs of children and families are always changing as is the system in which the work is done. A learning organization increases the probability that an organization has a competent, creative, and adaptable workforce.

The following areas of focus are identified to help build a learning environment within CA:

- ❖ *Assessment and Revisions to Academy and Post-Academy Training Plan and Curriculum:* Review and modify with consultation from the University of Washington, School of Social Work training curriculums to ensure opportunities to integrate and promote learning activities are included. (*Curriculum review December 2010, Revisions to training Year 2011*)
- ❖ *Quality Assurance and Continuous Quality Improvement Activities:* Provide meaningful and real time data regarding our compliance with policy and procedures, the quality of our work, and lessons learned from internal and external reviews to enhance knowledge and skills, and organizational problem solving capacity. See foundational strategy for [Quality Assurance \(QA\) and Continuous Quality Improvement \(CQI\)](#) (click on link)
- ❖ *Strengthen Clinical Supervision:* The activities to strengthen clinical supervision are in direct concert with a learning environment. While clinical supervision is focused primarily on the social work supervisor, the ideas and strategies will be expanded to social workers and managers to help build and promote an environment of open and active learning. See foundational strategy for [See Foundational Strategy](#) (click on link)
- ❖ *Integration of Solution Based Casework:* SBC provides the framework for which social workers focus their day-to-day work with children and families. Training, case consultation, and SBC QA/CQI activities teach and promote values, skills and practices of a learning environment. See foundational strategy for [Solution Based Casework](#) (click on link)
- ❖ *Develop and Implement Assessment Instruments:* To assess and respond to findings regarding appreciative and evaluative inquiry, workplace learning climate, and efforts to sustain organizational learning. (*Ongoing*)

INCREASE USE OF FAMLINK AS CA'S INFORMATION AND CASE MANAGEMENT TOOL TO SUPPORT AND ENHANCE PRACTICE

CA is committed to the use of FamLink as our information and case management tool to support quality practice and consistency of services to children and families. FamLink is an integrated system that provides a vehicle for case management, provider management, and payments. FamLink supports our practice with tools and information about the children and families we serve. It the intent of CA that staff use FamLink in day-to-day activities to manage and guide their work, view FamLink as a helpful system and more than a place to document activities.

The appropriate and timely use of FamLink as a case management tool will help CA improve performance by ensuring practice expectations are met and information is accurately reflected in the system. When FamLink data is incomplete or inaccurate, our ability to help children and families is hindered.

To strengthen integration and use of FamLink as our case management tool, the following will continue to be key areas of focus:

- ❖ *Leadership:* Reinforce CA commitment we use and rely on FamLink as our case management tool. Communicate expectations regarding the use of FamLink. Hold discussions with staff regarding the importance of FamLink as an essential business function, including the use of required practice tools and the value of entering information at the earliest possible time to better manage cases as we move forward. *(Beginning September 2009)*
- ❖ *Support:* Assign staff to provide and coordinate FamLink training and support. Identify on-site Peer Tutors to support one another in their use of FamLink. *(October 2009)*
- ❖ *Training:* Continue to assess individual competencies and develop and implement training plans, as applicable, with staff to grow their knowledge, skills, and abilities. Provide ready access to how-to information, on-line training, and quick help guides. Regularly assess and respond to office, regional, and statewide training needs. *(Beginning January 2010)*
- ❖ *Accountability:* Identify and communicate expectations regarding the use of FamLink. Update social workers' and supervisors' Position Description Forms (PDF) and Performance and Development Plans (PDP) to include this practice expectation. Ensure competency, consistency and accuracy in the use of FamLink. *(Beginning January 2010)*
- ❖ *Monitor and Track:* Continue to use and develop auditing and performance management reports to help identify staff's use of key requirements and practice tools in FamLink. Require supervisors to use FamLink as part of their supervisory review functions. Build capacity for additional auditing activities, including increased responsibility for quality assurance review activities. *(Beginning September 2009)*

PROVIDE ADULT MENTORS FOR FOSTER CHILDREN

Mentoring programs provide children and youth an additional health adult relationship. These adults provide care and concern, support and guidance for children and youth who face significant challenges in their lives.

Research conducted by Big Brothers Big Sisters has demonstrated that children with mentors are less likely to use drug and alcohol, more likely to attend school and have improved relationships with family and peers.

Washington State public agencies have had success by providing youth mentors, particularly in the Juvenile Rehabilitation Administration.

CA is committed to working with the Washington State Mentoring Program to develop and begin to implement a new practice expectation to provide children/youth in foster care with adult mentors through the following actions:

- ❖ Collaborate and receive technical assistance from the Washington State Mentors Program through a committee process co-chaired by the Director of the State Mentoring Program and CA Program Manager from Region 6. *(Beginning March 2010)*
- ❖ Identify existing community resources and assess capacity. *(June 2010)*
- ❖ Determine how CA can coordinate with community mentoring programs including the feasibility of prioritizing adult mentors for children in foster care. *(July 2010)*
- ❖ Explore federal programs, such as AmeriCorps and Vista Volunteer program resources to determine how these services and funds can help to improve access to adult mentors for children and youth in foster care. *(July 2010)*
- ❖ Develop training curriculum and implementation materials for staff and caregivers that address the value for providing foster children with mentors, resources, and practice expectation for CA staff to make referrals to mentor programs, like Big Brother, Big Sisters. *(November 2011)*
- ❖ Develop and implement a mentoring program in early implementation sites in each region. *(Beginning January 2011)*
- ❖ Build on lessons learned from early implementation sites to develop and implement new policy and practice expectations for providing foster children an adult mentor statewide. *(Year 2011-2012)*



Georgia Department of Human Services/Division of Family and Children Services
and Casey Family Programs

Permanency Roundtable Project

Process Evaluation Report—Executive Summary

October 2009

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www.casey.org/publications/resources/garoundtable.htm**

I. Executive Summary

In the fall of 2008, Georgia's Department of Human Services (DHS),¹ Division of Family and Children Services (DFCS) and Casey Family Programs (Casey) developed a Permanency Roundtable Project to address permanency for children who had been in foster care for long periods of time. The project focused primarily on children in Fulton and DeKalb counties, as these two counties account for a large proportion of the state's children in care, and they are under a federal consent decree.²

Background

Because of the consent decree and the results of the state's 2007 federal child and family services review, on which the state missed most of the federal outcome targets, the agency's new leadership was keenly aware of the need for change. Under this new leadership, DFCS made significant changes in agency culture and practice, including a paradigm shift from an incident-based, child-centered focus to a family-centered, permanency-focused practice. Much of this shift was accomplished through the agency's newly established G-Force process. This continuing process includes monthly state, regional, and program leadership meetings to review agency practices and outcomes with the goal of improving outcomes. The process also facilitates open discussion and a learning environment within the agency.

In addition, DFCS recognized the need to develop a career ladder for casework staff with effective outcomes. Master practitioner positions (regional supervisory positions) were created to provide leadership to case managers and supervisors in the field.

The permanency roundtable project described in this report was designed to capitalize on these changes already underway, with the roundtables designed for the dual purposes of addressing permanency for children and serving as a "learning lab" for casework staff.

Goals and Outcomes

The primary goals of the project were to expedite safe permanency for the children and to increase staff development around expediting safe permanency. The key child outcomes, to be measured approximately 12 and 24 months after the conclusion of the project roundtables, are (1) the children's progress toward and/or achievement of legal permanency; (2) changes, if any, in the level of restrictiveness of the children's living arrangements; and (3) reentry into placement by any of the children. Staff development outcomes (e.g., changes in practice based on the roundtable experience) will be measured via a participant evaluation distributed about three months after the end of the project roundtables.

1 The Department of Human Services (DHS) changed its name from the Department of Human Resources (DHR) effective July 1, 2009.

2 In 2006, county defendants and lawsuit plaintiffs entered into a consent decree approved by the United States District Court in the Northern District of Georgia. The Kenny A. consent decree required DFCS defendants to make system changes and to comply with 31 specific outcome measures regarding children in foster care.

The Children

Permanency roundtables were completed on 496 children and youth in care. These children were mostly pre-teens and teens with behavioral and/or mental health needs. Most of the children (63%) had been in foster care for over two years since their most recent foster care admission; the median length of stay was four years. Many of these children were considered “stuck” in foster care.

Roundtable Staffing and Preparation

The core roundtable teams typically consisted of a Casey permanency expert (staff or consultant), a DFCS master practitioner, the child’s case manager and supervisor, and a DFCS administrator or practice expert.

A two-day orientation to the permanency roundtables and additional training sessions were conducted in December 2008. The orientation, which included presentations by DFCS state leadership as well as Casey leadership, set the stage for the project.

The Roundtables

The roundtables were held in January and February 2009 at two DFCS county offices, one in Fulton and one in DeKalb. Ten roundtable teams staffed 496 children over a six-week period. Prior to participating in the roundtables, case managers and supervisors prepared a detailed written case summary and an oral case presentation. Roundtable teams accessed the case summaries in advance of the consultations via a secure project Web site.

During the two-hour roundtables, case managers presented the child’s case, and then the roundtable team discussed the permanency barriers and brainstormed permanency strategies for the child, using a structured format. A permanency action plan was then developed for the case manager to implement following the roundtable.

Master practitioners and permanency experts provided case managers and supervisors with support in planning and decision-making and modeled case consultation skills. These consultants, who could easily have been perceived as threatening, were accepted by casework staff because of the culture change groundwork that had been laid and because the roundtables were positioned as a tool to achieve permanency for children and improving staff skills, not as a review or assessment of previous work.

Besides the inclusion of external permanency experts, a unique feature of this project was the on-site and telephone availability of legal, policy, adoption, and other state staff resources for immediate consultation and “barrier-busting.”

Data Collection and Tracking

To assist with data collection, tracking, and evaluation, the state recommended a partner with a long history of working with DFCS, including work on the state’s federal child and family services review and resulting program improvement plan. The firm’s expertise in both child welfare and technology, includ-

An Early Success:

Anthony, age 14, had lived in foster care since 2004 due to neglect by his mother. His mother’s rights were terminated when he was 12, and his sister was adopted.

The roundtable team recommended that the case manager explore the father of Anthony’s half-sisters, ages 18 and 19, as a permanency resource, as Anthony visited his half-sisters monthly and had fond memories of those visits.

The case manager followed up with the siblings’ father, who agreed to legal guardianship of Anthony. Guardianship was finalized on July 15, 2009.

ing Web and database design, facilitated the project's implementation. The firm assisted in the development of roundtable evaluation forms, developed the project tracking system, and served as the project evaluator.

Following the roundtables, all of the case summary and roundtable consultation data were entered into a project tracking system to support the project's implementation and outcome evaluation. This system was used to manage the roundtable scheduling and staffing, the up-front case documentation, the strategies and action plans developed by the roundtable teams, and subsequent follow-up.

Post-Roundtable Follow-Up

To facilitate the permanency process internally, DFCS and Casey recognized the need for a state-level permanency coordinator to monitor and track the progress of the roundtables, the implementation of the permanency action plans, and the results for the children staffed. This permanency coordinator supervised project implementation and follow-up and continued to support positive permanency practices.

Following the roundtables, DFCS master practitioners and the child's case manager and supervisor met and continued to meet monthly to discuss and support progress to ensure follow-through on roundtable recommendations. The permanency coordinator conducted monthly conference calls and meetings on an ongoing basis to track each child's status, the status of any waiver requests (such as policy or legal), and action plan implementation.

Because of the positive feedback from case managers and the increase in permanency planning, and inspired by early indications of success, DFCS master practitioners implemented permanency roundtables in each region statewide. As of June 30, 2009, an additional 1,628 roundtables had been conducted, and DFCS plans to continue roundtable implementation in all regions.

Permanency Barriers

Case managers were asked to indicate up to three key barriers to the child's permanency on the Case Summary Form. Note that these descriptions of barriers preceded the roundtable process and may reflect case managers' preconceived notions about the case or what actually constitutes a barrier. In some cases (for example, "child's situation improving"), it seems the case manager used the field to provide information for the roundtable team rather than identify a specific barrier. Highlights regarding barriers include:

- **The identification of 841 barriers.**
- **For nearly two-thirds of the children, a key barrier had to do with a child issue, most commonly the child's behavior, social and emotional issues, age, and/or mental health issues.**
- **For just over one-third of the children, a key barrier was a birth family barrier, with a birth parent's lack of employment, income, and/or housing being most commonly cited, followed by poor cooperation in working the case plan, and ongoing maltreatment.**

Leadership Comment:

"If we had not used a group like Care Solutions with a clear understanding of our business and the technological know-how to develop the evaluation tools and tracking system database in a short period of time, we would not have been able to implement the roundtables project as quickly as we did. This would be difficult to duplicate... the existing relationships, trust, and competence made it work."

- For nearly one-third of the children, a key barrier related to the potential permanency resource or lack thereof. Note that “resource” in this situation can be a person willing to care for the child on a more permanent basis.
- For nearly one-third of the children, a key barrier was a child welfare system barrier, most commonly waiting on a court or legal process, such as termination of parental rights or the appeal of a termination of parental rights.

Permanency Goals and Action Plans

The key output of the roundtable consultations was the development of permanency action plans with specific strategies and actions designed to move each child toward permanency. For most of the children (78%), the permanency roundtable team did not recommend a change in the child’s permanency goal (e.g., reunification, adoption, guardianship), just strategies and actions designed to expedite legal permanency for the child. For nearly one in five children (18%), the permanency roundtable team recommended a change in the child’s permanency goal (see Table 14).

Permanency action plans were developed for 487 children with 3,147 action steps, an average of seven steps per plan. The action steps most commonly dealt with (1) improving the child’s well-being, (2) providing supports/resources for caregivers so that they might become a permanency resource for the child, and (3) locating and engaging permanency resources (27%, 21%, and 18% of the action steps, respectively).

 Overall, the key strengths of the permanency roundtables were the involvement and commitment of all involved—from DFCS state, regional, and local leadership to supervisors and front-line staff, as well as the Casey project leadership and permanency experts. 

Strengths, Challenges, and Recommendations of the Roundtable Process

The project generated many lessons for other such efforts. Following is a list of key strengths, challenges, and recommendations of the roundtable process divided into the following categories: logistics, training, technical assistance and quality assurance, and data collection.

While specific to the Georgia project, these lessons learned will assist replications in Georgia and elsewhere.

Logistics:

A. Roundtable Locations

- **Strength:** Holding roundtables at two county DFCS offices reduced travel and time costs for case managers and supervisors.
- **Challenge:** Holding roundtables at two sites resulted in some participants comparing locations. There were perceptions that one site had more human and technological resources available than the other site.
- **Recommendation:** If multiple locations are used, ensure equitable resource and support allocation. For example, wireless connections could increase efficiency by allowing for access to online resources and uploading of current materials.

B. Resource Availability

- **Strength:** Having state-level policy, legal, and other resources available on-site and by telephone for immediate access during the roundtables allowed for immediate advice and other assistance.
- **Challenge:** Some teams were not aware of resource availability, and resource availability varied by site and by day.
- **Recommendation:** Publish or announce resource availability in advance and how it can be accessed prior to roundtables, provide all groups with contact information for off-site resources, and have a message board for posting updates.

C. Intense Scheduling

- **Strength:** The roundtable scheduling allowed for the staffing of a large number of cases in a short time span.
- **Challenge:** The intense schedule and process took its toll on participants.
- **Recommendation:** Limit roundtables to three or four days per week and eight hours per day.

D. Sibling Groups

- **Strength #1:** Identified sibling groups were scheduled in adjacent time slots so that those consultations could be done together by a single team with adequate consultation time.
- **Challenge #1:** Some sibling groups with similar situations only required one time slot; other sibling groups with dissimilar situations (different fathers, different placements, etc.) required more time.
- **Recommendation #1:** Try to identify these differences ahead of time and schedule accordingly.

Debriefing Comment:

“It is important to make sure the focus is not just on permanency, but instead on positive, beneficial permanency. Staffing cases that are close to permanency is a great way to focus on making sure the child has, and will continue to have, access to the necessary post-adoption resources.”

- **Strength #2:** Every attempt was made to staff siblings together if any member of the sibling group was in the target population, so that they all would benefit from the roundtable permanency expertise and planning.
- **Challenge #2:** The resulting last-minute insertions and schedule changes led to some confusion about whether a few of the children had been staffed and to incomplete paperwork and documentation on some of these children.
- **Recommendation #2:** Identify sibling groups that may not fall into the target cohort and include them in advance so case summaries and child information are readily available at the roundtable and time can be allocated accordingly.

E. “On-Deck Cases”

- **Strength:** Having the roundtables at the county DFCS offices allowed “on-deck” cases (cases previously prepared for consultation) from those counties to be inserted into the schedule as time permitted.
- **Challenge:** Last-minute rescheduling due to real-life situations (e.g., case emergencies) and adding cases that were not prepared to be “on-deck” led to paperwork and information gaps that hindered the roundtable discussion.
- **Recommendation:** Establish an “on-deck” procedure to ensure availability of information (including prior review of case summaries) for roundtable team in advance of adding a case when time permits.

F. Secure Web Site

- **Strength:** A secure Web site with limited permissions allowed for online posting of the master schedule, case summaries, and project forms so that roundtable team members could access these in advance while child privacy was maintained; it also provided a location to post resource information for staff and teams.
- **Challenge #1:** Frequent schedule changes that affected staffing meant that sometimes roundtable participants could not identify and access their cases in time to prepare for the next day’s roundtables.
- **Recommendation #1:** Minimize schedule changes with earlier and more targeted scheduling of cases, and set up Web site security permissions so that those with case staffing responsibilities are able to view any child’s record.
- **Challenge #2:** Although designed to facilitate communication, the Web site was under-utilized.
- **Recommendation #2:** Provide hands-on trainings and demonstrations for roundtable participants prior to implementation on how the Web site can increase communication and preparation.

Master Practitioner Comment:

“The process seems magical. It brings everyone together to consider what is best for all children in care, and gives us permission to consider everything as being possible in securing what is best for our children.”

Training:

A. Two-Day Orientation

- **Strength:** A two-day orientation with presentations by top agency leadership served to generate excitement and enthusiasm for the project among DFCS regional leadership, master practitioners, and supervisors as well as Casey permanency experts; subsequent case manager trainings provided smaller forums for familiarizing staff with the process, forms, and answering questions.
- **Challenge:** Caseworkers did not receive the same level and intensity of training (and networking opportunities with experts) since they did not participate in the two-day orientation.
- **Recommendation:** Provide equivalent level and intensity of training for case managers, including their participation in orientation and more training on completing forms and preparing for case presentations. Case managers are ultimately responsible for implementing the action plans and moving the child toward permanency.

B. Sharing Learning

- **Strength:** Participation of Casey permanency experts, availability of on-site expertise, and the roundtable group discussion format provided many opportunities for field casework staff to learn within the roundtables and at informal lunch discussions.
- **Challenge:** Sharing learning on the fly effectively.
- **Recommendation:** Provide additional opportunities for sharing learning across roundtables and with non-participating staff in person or online including “lunch-and-learn,” message boards, and blogging.

Technical Assistance and Quality Assurance:

A. Action Planning

- **Strength:** The structured planning phase of the roundtable consultations encouraged creative thinking and solutions to overcoming permanency barriers for children.
- **Challenge:** There was a wide range in the quality of the action plans, with some lacking in substance and clarity in the documentation. While all action plans developed during the first week of roundtables were reviewed by experts who gave feedback to the teams, this practice was not continued through the four subsequent weeks.
- **Recommendation:** Provide more up-front training on writing action plans and build in time for ongoing reviews and quality checks of the action plans. For example, expert staff who are not participating in roundtables could review plans as they are generated and provide immediate feedback.

B. Roundtable Forms

- **Strength:** The roundtable forms provided participants with a wealth of information about each child being staffed and a way to document the status, permanency goals, and plans for the child.
- **Challenge #1:** The tight time frame in planning and implementation of the roundtables did not allow for field testing of the forms.

- **Recommendation #1:** Pilot-test forms with case managers and supervisors.
- **Challenge #2:** There were too many open-ended questions and some redundancy on the forms, due in part to the assumption that a section of the form would be pre-populated with data from the state's data system, which did not occur.
- **Recommendation #2:** Streamline forms; pre-code responses wherever possible to reduce the amount of hand-coded data.
- **Challenge #3:** Forms were sometimes missing and/or incomplete.
- **Recommendation #3:** Have supervisors check case summary forms for completeness before submission to the roundtable team; provide on-site checking of roundtable forms at the conclusion of each roundtable to ensure completeness of the documentation.

Data Collection:

A. Data Tracking

- **Strength:** A project data-tracking system allowed for the collecting and storing of extensive project data on the roundtables and the children staffed. It also allowed for the addition of tracking child status, plan changes, and implementation status.
- **Challenge #1:** The inability to download data from SHINES, Georgia's statewide automated child welfare information system, resulted in (1) the case managers having to complete additional paperwork and (2) additional data entry costs.
- **Recommendation #1:** Specific requests for data and technical assistance from the state data system should be made as early as possible so that any additional work required to extract needed data can be completed in advance. This will reduce the volume of information that case managers must complete and the amount of data entry and data cleaning required, and will help avoid confusion created by inconsistencies in form completion wherever possible.
- **Challenge #2:** The short development time frame led to insufficient database and data entry testing, which resulted in re-entering of data.
- **Recommendation #2:** Allow more time for development and testing of databases.

B. Roundtable Staffing and Documentation

- **Strength:** Roundtables included both a Casey permanency expert and a DFCS master practitioner, and some roundtables had two master practitioners.
- **Challenge:** Some roundtable sessions did not have a designated note-taker.
- **Recommendation:** Assign a note-taker as part of scheduling and leave time at the end of each session to review the written goals, strategies, and actions to ensure completeness and clarity. The designated note-taker could be the second master practitioner if two are assigned to each team. Relieving the core participants of the burden of note-taking would allow them to be more creative and maintain the momentum of the discussion.

Formula for Success

Based on participant feedback and evaluator observation, the following are offered as keys to success for similar endeavors:

- Leadership support and visibility in all phases of the project are critical to implementation.
- Clearly communicating that the roundtables would be prospective and innovative rather than retrospective and fault-finding is essential in obtaining buy-in from front-line staff.
- Orientation and training, with leadership participation, can set the stage for a positive approach to the project.
- Outside expertise, technical assistance, and support are critical to the project.
- Having a group process that includes experts and practitioners not previously involved in the case is helpful to identifying alternative resources and strategies.
- The roundtable process itself creates a significant focus on the children and their individual situations as well as the work of the case managers.
- A clear structure and format for the case consultations promotes balanced discussion and thorough consideration of permanency options.
- A project data-tracking system to manage and track scheduling, project data, and consultation outputs is a must for project implementation and follow-up.
- Ongoing positive feedback maintains enthusiasm throughout the project.
- Additional (1) up-front planning, training, and technical assistance, and (2) ongoing quality assurance and technical assistance—especially in the areas of documentation, data collection, and permanency plan development—will facilitate and strengthen the process.
- A process within the agency for ongoing monitoring and support of permanency plan implementation is essential.

Conclusions

The Permanency Roundtable Project represented a significant effort to move children in care for longer periods of time to permanency and to increase staff skills in permanency strategies and planning. A total of 496 cases were staffed with DFCS personnel and external experts in a very short time. The roundtables led to identifying 841 barriers and the creation of 3,147 action steps, and there were some early success stories that supported the optimism and enthusiasm of all involved. According to DFCS, as of July 10, 2009, five months after the completion of the roundtables, 82 (17%) of the children staffed had already achieved positive legal permanency (33 reunifications, 13 in the custody of a fit and willing relative, 15 adoptions, and 21 guardianships). There were also 28 emancipations, with 27 signing voluntary agreements to remain in foster care. These early successes may be attributed to immediate work on implementing action plans, ongoing monitoring and tracking, and staff and consultants who remained flexible and positive when adjustments were necessary. It is hoped that the successful project implementation and hard work of all participants will translate into greater permanency for youth in DFCS care.



Casey Family Programs' mission is to provide and improve—and ultimately prevent the need for—foster care. Established by UPS founder Jim Casey in 1966, the foundation provides direct services and promotes advances in child welfare practice and policy.

Casey Family Programs

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Attachment 2

Tables of Ten: An Overview

Tables of Ten is an intervention designed by the University of Washington School of Law's Court Improvement Training Academy to promote the growth of learning communities in child welfare legal systems on a county level. Although individual Tables of Ten address concrete issues in their respective systems, the intervention itself is designed more as a way of building a learning community that can develop approaches to a variety of issues facing the system than as a specific intervention for any one problem. At its core, Tables of Ten is focused on developing a learning community that can work together to resolve a variety of issues.

Theoretical Base

Tables of Ten are rooted in concepts derived from adult learning, leadership, systems, and implementation theory. Each of these theoretical foundations interlink with one another to form an approach aimed at developing a meaningful learning community capable of resolving significant issues.

Adaptive Leadership

Adaptive leadership theory is key to Tables of Ten¹. Although technical problems with defined solutions may be addressed, the more significant work of the Tale of Ten is to address adaptive challenges facing the child welfare legal community in a specific county. In this context, adaptive challenges fundamentally address one of two questions: 1. How can we come to an agreement on the values of our system as a whole? 2. Does our reality reflect that which we say we value, and if not, what is necessary to achieve congruence between the two?

Adult Learning

Much of the work of Tables of Ten is viewed through the lens of adult learning theory². Specifically, problems are approached from a practical perspective given that most adult learners are more willing to learn and implement change in a setting that addresses concrete needs as opposed to abstract non-specific academic material. Tables of Ten are designed to address system needs as perceived by those in the system rather than an abstract standard or pre-formed set of universal norms imposed by those outside the local community.

Systems Thinking

Tables of Ten are encouraged to view issues through a systems thinking lens.³ No one part of the system is either the sole source of the problem, nor the only entity with the solution. A

¹ See Heifetz, R. (2004). *Leadership Without Easy Answers*. Cambridge MA: Belknap Press.

² See Knowles, M. (2005). *The Adult Learner*. Burlington, MA: Elsevier Press.

³ See Senge, P. (2006). *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Doubleday Press.

Attachment 2

holistic approach is encouraged. Systems mapping tools are employed to identify key leverage points where minimum effort can result in maximum return.

Measurable Results

Tables of Ten is a results oriented intervention. The learning community defines the result it seeks, and is encouraged to monitor both objective and subjective change in the system. The combination of clear systemic values and an eye toward measurable change allows for sustained change efforts across multiple disciplines and through a variety of interconnected systems.

Practical Application

Tables of Ten are comprised of ten individuals from a given county interested in improving the local child welfare legal system. The group is multidisciplinary in nature and typically consists of a judicial officer, assistant attorney general, parent's attorney, guardian ad litem or CASA manager, DSHS Children's Administration representative, and others. The group is initially invited to a two day training. The first day of the training focuses on leadership tools and development of a mission statement that expresses the intent of the child welfare legal system as a whole. The second day of the training is divided into several parts including a statistical review of county level data, mapping of the child welfare legal system, identification of key data and leverage points, and an opportunity to develop an influence plan to positively impact the system. Tables of Ten are then encouraged to meet on a regular basis to continue to develop and monitor their plans. The University of Washington Court Improvement Training Academy, as sponsor of the program, continues to provide technical and training support on an as needed basis.

Current Status

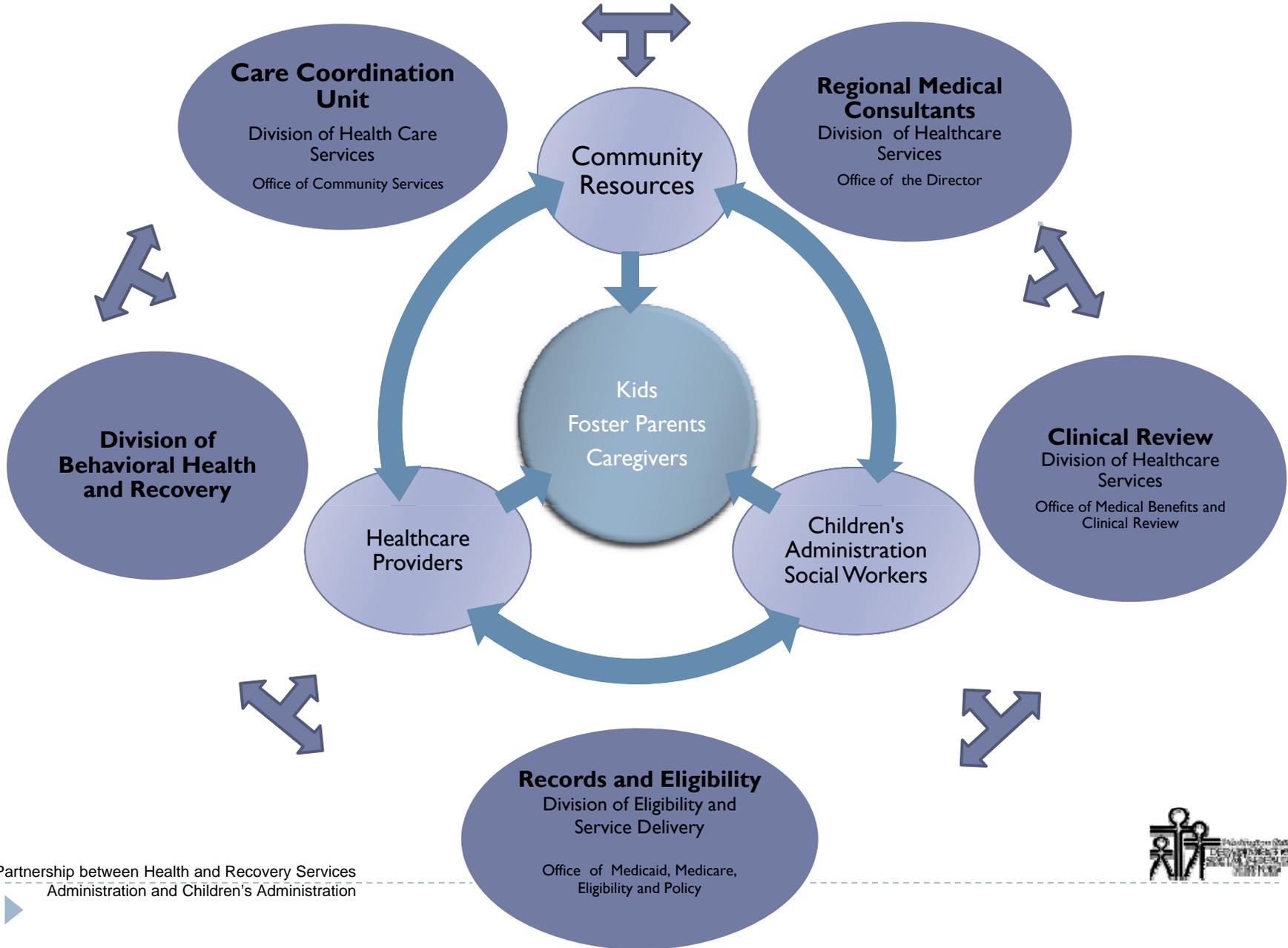
Funded through a contract with the Washington State Administrative Office of the Courts using Federal Court Improvement Program Training Grant dollars, Tables of Ten have been conducted in nine counties since August 2008⁴. Seven of the nine sites continue to meet regularly. Three of the sites are in various stages of exploring interventions to improve outcomes for children as part of projects developed in partnership with Partners for Our Children. One county has demonstrated significantly improved case processing times, and others have used Table of Ten as a means to specifically focus on improving cross discipline relationships. Virtually all of the Tables of Ten have used the program as a base to encourage and develop broad cross-disciplinary training initiatives focused on improving the local child welfare legal system by enhancing skill development, broadening individual's knowledge base, and focusing on systemic reform at the operational level.

For additional information relating to Table of Ten, contact CITA director Tim Jaasko-Fisher at 206.616.7784 or via e-mail at tjfisher@uw.edu.

⁴ Tables of Ten have been conducted in the following counties: Stevens / Ferry (8/08), Skagit (9/08), Whatcom (9/08), Thurston (9/08), Lewis (9/08), Kitsap (9/08), Snohomish (11/09), Grant (1/10), and Grays Harbor (2/10).

Fostering Well-Being

Person Centered Health Services for Children in Out of Home Placement





2010 Fact Sheet

Fostering Well-Being Program: A Partnership between Health and Recovery Services Administration and Children's Administration

WHAT IS THE NEW FOSTERING WELL-BEING PROGRAM?

The Department of Social and Health Services is committed to improving healthcare services for children in out-of-home placement. A new program in the Health and Recovery Services Administration (HRSA) called Fostering Well-Being is a collaborative effort between HRSA and Children's Administration. Fostering Well-Being uses a person-centered health model to address the comprehensive healthcare needs for children in out-of-home placement. This program will better align the Department's resources to improve health outcomes for these children.

WHAT ARE THE MAJOR COMPONENTS OF THIS PROGRAM?

- ▶ Medical ID cards issued to all children in out-of-home placement within three working days of placement notification
- ▶ Healthcare reports mailed to foster parents and caregivers within three working days of initial placement notification
- ▶ Medical records requested for the last two years for all children in out-of-home placement for more than 30 days
- ▶ Early and Periodic Screening Diagnosis & Treatment (EPSDT) or Well-Child Exam reminders sent to foster parents and caregivers
- ▶ Care coordination provided for a subset of medically complex children
- ▶ Health education materials mailed to foster families for children with certain health conditions
- ▶ Six Regional Medical Consultants continue to be a vital link for social workers, foster families and local medical communities

WHAT IS CARE COORDINATION?

Care coordination services assure access to effective and comprehensive healthcare for children in out-of-home placement that addresses their interrelated medical, dental, mental health, chemical dependency, and developmental needs to achieve optimal health and wellness outcomes.

WHAT ARE THE GOALS OF CARE COORDINATION?

- ▶ Support and promote access to a person-centered health home to address health-related needs
- ▶ Coordinate effective linkages between foster families and relative caregivers; community-based health care services including primary care providers, specialty care, mental health and substance abuse agencies; state and local agencies; and other key partners
- ▶ Increase EPSDT examination rates
- ▶ Measure and evaluate interventions to achieve optimal health and wellness outcomes

FOR MORE INFORMATION CONTACT:

Fostering Well-Being Care Coordination Unit Supervisor Christina Garcia, 360-725-1737
Children's Administration Health Program Manager Michelle Bogart, 360-902-8006



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Field Operations Division - Children's Administration
Olympia, Washington 98504-5710

March 8, 2010

TO: CA Regional Administrators and Area Administrators
CHET Regional Supervisors and CHET Screening Specialists
CA Supervisors
CA Social Workers

CC: CA Directors
CA Statewide CHET Program Manager and Supervisor
CA Quality Assurance Manager

FROM: Becky Smith, Acting Director, Field Operations Division, CA

SUBJECT: **CHILD HEALTH & EDUCATION TRACKING (CHET) POLICY AND PRACTICE EXPECTATIONS**

Our current policy and practice expectation is for all children who are expected to remain in care for 30 days or more to have a completed CHET Screen within 30 days. The purpose of this screening is to assess the child's current well-being and is used to develop effective case plans at the Shared Planning Meeting held within 30 days, but no later than 60 days.

CHET Screening Specialists are working hard to complete the CHET Screen within 30 days so the information can be reviewed and addressed at the 30 day Shared Planning Meeting. It is imperative we hold and document case staffings, including Shared Planning meetings that address CHET screening results within 60 days.

In reviewing our progress and discussing current practices related to these staffings, it is apparent this is an area of practice that needs some improvement. To strengthen our practice, below is clarification regarding staff's roles and responsibilities for CHET Shared Planning staffings:

Social Worker

- Document child's placement in FamLink as soon as possible
 - Ensure the child/youth's CHET Screening results are addressed during the 30 day Shared Planning meet and/or a separate CHET Shared Planning meeting is scheduled no later than 60 days from placement in out of home care
 - Ensure the child/youth (12 and above), child's parent(s), caregiver, and CHET Screening Specialist are invited to the Shared Planning meeting that includes review and discussion of the CHET Screening Report
 - Confirm with the caregiver he/she received a copy of the CHET Screening Report
 - Document the CHET Shared Planning meeting in FamLink
- Link to FamLink documentation tips: [CHET Outcome - Shared Planning](#)

CHET Policy and Practice Expectations
Page 2 – Continued

Social Worker Supervisor

Use the Monthly Supervisor Review to ensure the social worker:

- Received and reviewed the CHET Screening Report
- The child/youth's CHET Screening results were addressed during the 30 day Shared Planning meeting or a separate CHET Shared Planning meeting occurs no later than 60 days from the child/youth's entry into care
- Ensure the child/youth, parent, caregiver, and CHET Screening Specialist are invited to the Shared Planning meeting to review and discuss the CHET Screening Report
- Confirmed the caregiver received a copy of the CHET Screening Report
- Documented the CHET Shared Planning meeting in FamLink

CHET Screening Specialist

- Complete the CHET Screen and corresponding report within 30 days of a child/youth's entry into care per policy and no later than 45 days if a comprehensive mental health assessment is needed
- Provide a copy of the CHET Screening Report to the child's assigned social worker and caregiver within five working days of completion
- Make active efforts to ensure the social worker is aware of the requirement to hold the staffing and be readily available to participate in the CHET Shared Planning Meeting

Regional CHET Supervisor

- Ensure timely completion of CHET Screening Reports
- Ensure CHET Screening reports are provided to the assigned social worker and caregiver within five working days of completion
- Make active efforts to ensure CHET Shared Planning meetings are held within 60 days of a child/youth's entry to care
- Coordinate with social work supervisors and managers as needed to ensure CHET Screening Specialists are invited and participate in CHET Shared Planning meetings
- Track documentation of the CHET Shared Planning Meeting in FamLink and follow up as necessary with the social worker supervisor

I appreciate your attention to strengthen our practice to identify, address and document the physical health, developmental, emotional/behavioral, education and connections for a child, and identify and coordinate services to support their healthy development.

Policy Links:

[PP Guide - Section 4301](#)

[PP Guide - CHET Policy](#)

ITEIP Referrals Report

Reflects new program definitions effective 2/1/2009

Developmental Domain - Age limited from Birth to 36 months

Placements between 11/01/2009 and 11/30/2009

Region		Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
1			4	0	0	0	1
80%	Referrals made within 2 days		80%	0%	0%	0%	20%
		A. Number of required developmental screenings			18		
		B. Number of children with an identified concern			5		
		C. Number of children with an identified concern not referred to ITEIP			1		
		D. Number of children with identified concerns referred to ITEIP			4	% of B	80%
2			6	0	1	0	0
86%	Referrals made within 2 days		86%	0%	14%	0%	0%
		A. Number of required developmental screenings			13		
		B. Number of children with an identified concern			7		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			7	% of B	100%
3			14	0	0	0	0
100%	Referrals made within 2 days		100%	0%	0%	0%	0%
		A. Number of required developmental screenings			32		
		B. Number of children with an identified concern			14		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			14	% of B	100%
4			4	0	0	0	0
100%	Referrals made within 2 days		100%	0%	0%	0%	0%
		A. Number of required developmental screenings			19		
		B. Number of children with an identified concern			4		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			4	% of B	100%

Data is based on all required CHET screens.

This report reflects data that has been entered into the statewide CHET database, not FamLink.

The data in this report is in the process of being validated by Regional field staff.

Attachment 6

Region	5	Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
75%	Referrals made within 2 days		3	0	0	0	1
			75%	0%	0%	0%	25%
		A. Number of required developmental screenings			26		
		B. Number of children with an identified concern			4		
		C. Number of children with an identified concern not referred to ITEIP			1		
		D. Number of children with identified concerns referred to ITEIP			3	% of B	75%
Region	6	Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
100%	Referrals made within 2 days		4	0	0	0	0
			100%	0%	0%	0%	0%
		A. Number of required developmental screenings			14		
		B. Number of children with an identified concern			4		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			4	% of B	100%
State		Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
92%	Referrals made within 2 days		35	0	1	0	2
			92%	0%	3%	0%	5%
		A. Number of required developmental screenings			122		
		B. Number of children with an identified concern			38		
		C. Number of children with an identified concern not referred to ITEIP			2		
		D. Number of children with identified concerns referred to ITEIP			36	% of B	95%

Data is based on all required CHET screens.

This report reflects data that has been entered into the statewide CHET database, not FamLink.

The data in this report is in the process of being validated by Regional field staff.

ITEIP Referrals Report

Reflects new program definitions effective 2/1/2009

Developmental Domain - Age limited from Birth to 36 months

Placements between 12/01/2009 and 12/31/2009

Region		Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
1			4	0	0	0	2
67%	Referrals made within 2 days		67%	0%	0%	0%	33%
		A. Number of required developmental screenings			19		
		B. Number of children with an identified concern			6		
		C. Number of children with an identified concern not referred to ITEIP			2		
		D. Number of children with identified concerns referred to ITEIP			4	% of B	67%
2			4	0	0	0	1
100%	Referrals made within 2 days		100%	0%	0%	0%	25%
		A. Number of required developmental screenings			16		
		B. Number of children with an identified concern			4		
		C. Number of children with an identified concern not referred to ITEIP			1		
		D. Number of children with identified concerns referred to ITEIP			3	% of B	75%
3			10	0	0	0	0
100%	Referrals made within 2 days		100%	0%	0%	0%	0%
		A. Number of required developmental screenings			20		
		B. Number of children with an identified concern			10		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			10	% of B	100%
4			6	0	0	0	0
100%	Referrals made within 2 days		100%	0%	0%	0%	0%
		A. Number of required developmental screenings			23		
		B. Number of children with an identified concern			6		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			6	% of B	100%

Data is based on all required CHET screens.

This report reflects data that has been entered into the statewide CHET database, not FamLink.

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Region	5	Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
83%	Referrals made within 2 days		5	0	0	0	1
			83%	0%	0%	0%	17%
		A. Number of required developmental screenings			22		
		B. Number of children with an identified concern			6		
		C. Number of children with an identified concern not referred to ITEIP			1		
		D. Number of children with identified concerns referred to ITEIP			5	% of B	83%
Region	6	Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
100%	Referrals made within 2 days		10	0	0	0	0
			100%	0%	0%	0%	0%
		A. Number of required developmental screenings			24		
		B. Number of children with an identified concern			10		
		C. Number of children with an identified concern not referred to ITEIP			0		
		D. Number of children with identified concerns referred to ITEIP			10	% of B	100%
State		Number of DAYS ITEIP referrals were made in for children with identified concerns	0-2:	3-5:	6-10:	Over10:	Incomplete
93%	Referrals made within 2 days		39	0	0	0	4
			93%	0%	0%	0%	10%
		A. Number of required developmental screenings			124		
		B. Number of children with an identified concern			42		
		C. Number of children with an identified concern not referred to ITEIP			4		
		D. Number of children with identified concerns referred to ITEIP			38	% of B	90%

Data is based on all required CHET screens.

This report reflects data that has been entered into the statewide CHET database, not FamLink.

The data in this report is in the process of being validated by Regional field staff.



2010 Fact Sheet

Fostering Well-Being Care Coordination Unit

WHAT IS CARE COORDINATION?

Care coordination services assure access to effective and comprehensive healthcare for children in out-of-home placement. Care coordination addresses interrelated medical, dental, mental health, substance abuse, and developmental needs to achieve optimal health and wellness outcomes.

WHO IS ELIGIBLE FOR FOSTERING WELL-BEING CARE COORDINATION SERVICES?

Medically complex children in out-of-home placement for more than 30 days who meet one of the following criteria:

- Complex chronic health conditions
- Mental health crisis without treatment in the last 12 months
 - ER visit with mental health diagnosis
 - RSN crisis service
 - Psychiatric hospitalization
- Children age five and under receiving psychotropic medications
- In the last 12 months:
 - More than two hospitalizations
 - More than four ER visits
 - Failure to thrive and nutrition problems

WHAT SERVICES ARE INCLUDED IN CARE COORDINATION?

Coordinated effective linkages between caregivers and community-based healthcare services, state and local agencies, and other key partners are established. Care coordination activities include:

- Facilitate access to primary and specialty healthcare providers
- Analysis of medical records, billing data, immunization reports, social worker case notes, and Child Health Education and Tracking (CHET) screening reports
- Assess for gaps in care, including medical, dental, mental health, and substance abuse domains

WHO CAN MAKE A REFERRAL FOR CARE COORDINATION?

Social workers, CHET screeners, and Regional Medical Consultants. Caregivers may request a referral through their primary social worker.

WHAT IF I WANT TO MAKE A REFERRAL?

Email: dhsfwbccu@dshs.wa.gov or Fax: (360) 725-1722

FOR MORE INFORMATION CONTACT:

HRSA Fostering Well-Being Care Coordination Unit, 1-800-562-3022 x 59594 or dhsfwbccu@dshs.wa.gov

Data As Of : 3/14/2010 for January 2010 Visits

Region	CA Social Worker Visits	Visits by Other	Attempted Visits	No Visits	Total Children Needing Visit
Region 1	1100	26	28	107	1261
	87.23%	2.06%	2.22%	8.49%	100%
Region 2	839	25	14	77	955
	87.85%	2.62%	1.47%	8.06%	100%
Region 3	1291	9	12	70	1382
	93.42%	0.65%	0.87%	5.07%	100%
Region 4	960	30	28	77	1095
	87.67%	2.74%	2.56%	7.03%	100%
Region 5	1190	36	27	188	1441
	82.58%	2.50%	1.87%	13.05%	100%
Region 6	1212	59	12	157	1440
	84.17%	4.10%	0.83%	10.90%	100%
Region 7	3	0	0	0	3
	100.00%	0.00%	0.00%	0.00%	100%
Grand Total:	6585	185	121	676	7567
	87.02%	2.44%	1.60%	8.93%	100%

POLICY SUMMARY
Monthly Health and Safety Visits
Documentation
April 2010

When is it effective? April 30, 2010

Why are we making this change?

Ensures accurate documentation of monthly visit case activities

What does it mean to me?

FamLink documentation of Monthly Health and Safety Visits is now required within **seven (7)** calendar days from the date the visit occurs.

What is important to remember?

- The same **FamLink codes** apply:
 - **Health and Safety Monitoring Visit (CA Social Worker)**
 - **Health and Safety Visit (attempted)** should be used for informational purposes only. (*A visit must take place for compliance with policy.*)
 - **Health and Safety Monitoring Visit (conducted by other agency)**
 - *Used for out-of state ICPC visits*
 - *Visits completed by CPA social worker*
- NOTE: *A visit by a CPA SW does not relieve CA social workers from completing their monthly visits - Both visits MUST be documented in FamLink*
- Use the following code for visits with caregivers:
 - **Monthly Caregiver Contact (in-Person)**
- When documenting the Health and Safety Monitoring visits be sure to select the correct children (i.e. participants)

Resources associated with this policy:

- Practice and Procedures Guide – Chapter 4000, Section 4420 Social Worker Monthly Health and Safety Visits
- Policy Update Page: <http://ca.dshs.wa.gov/intranet/kcf2/swOuthome.asp>
- Guide for Monthly Social Worker Visits
- Checklist for Child and Caregiver Visits
- Braam documentation web page
http://ca.dshs.wa.gov/intranet/catrng/braam/braam_monthlyvisits.asp
- Tips for Caregivers (DSHS 22-0066)
- Monthly Visit Requirements – *Desk Aid*

If you have questions, please contact: Carrie Kendig at (360) 902-7568 or cken300@dshs.wa.gov



Health and Safety (H&S) Visit Requirements – Desk Aide

Health and Safety Visits must be completed with each child every calendar month, not to exceed 40 days between visits. Monthly visits are also required with Caregivers.

Case Type	Frequency of Visits	Location of Visit	Documentation Requirements	Other Clarifications
Out of Home Placement (CA Dependent children or children placed with a Voluntary Placement Agreement)	<p>The first visit must occur within seven calendar days of initial placement.</p> <p><i>(Placing a child is not considered a Health and Safety visit.)</i></p> <p>One visit each calendar month.</p>	<p>Majority (51%) of visits must occur in the home where the child resides</p>	<p>Social worker must document H&S visit with child within 7 calendar days of the visit, using the following code:</p> <ul style="list-style-type: none"> Child - H&S Monitoring Visit (CA Social Worker) value/code <p>Social worker visits with caregivers must be documented using the following code:</p> <ul style="list-style-type: none"> Monthly Caregiver Contact (in-Person) and ensure the correct child(ren) (i.e. participants) is/are selected <p>For Suitable Person - Use Monthly Caregiver Contact (in-Person) as it falls under the broad definition of relative</p> <p><i>Courtesy Supervision Social Worker will complete the H&S visit and documentation requirements.</i></p>	<p>Policy Link: http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4310.asp#4420</p>
ICPC Out of Home Placement (CA Dependent children)	<p>One visit each calendar month.</p>	<p>Majority (51%) of visits must occur in the home where the child resides</p>	<p>ICPC State/County SW or Private Agency Social Worker conducts the H&S monitoring visit with child in another state and assigned CA social worker must document within 7 calendar days of confirmation the visit was completed:</p> <ul style="list-style-type: none"> Child - H&S Monitoring Visit (Conducted by Other Agency) Monthly Caregiver Contact (in-Person) and ensure the correct child(ren) (i.e. participants) is/are selected 	<p>When the receiving state completes monthly H&S visits, but only submits written reports every 90-days, the CA social worker should contact the ICPC HQ office or the other state's social worker to request the date the child was seen and a status of the child's safety, permanency and well-being.</p> <p>This information is then documented in a FamLink using the appropriate code. This must be followed up by a review of the written 90-day report.</p> <p>If the receiving state refuses to complete</p>

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Program and Practice Improvement
April 2010

Case Type	Frequency of Visits	Location of Visit	Documentation Requirements	Other Clarifications
				monthly visits, the assigned social workers will continue to request monthly visits and document their efforts.
Voluntary In-Home Services Cases	One visit each calendar month.	Majority (51%) of visits must occur in the home where the child resides	<p>Social worker must document H&S visit with child within 7 calendar days of the visit, using the following code:</p> <ul style="list-style-type: none"> • Child - H&S Monitoring Visit (CA Social Worker) value/code <p>Social worker visits with parent/caregivers must be documented using the following code:</p> <ul style="list-style-type: none"> • Monthly Caregiver Contact (in-Person) and ensure the correct child(ren) (i.e. participants) is/are selected <p><i>Courtesy Supervision Social Worker will complete the H&S visit and documentation requirements.</i></p>	<p>Policy Link: http://www.dshs.wa.gov/ca/pubs/mnl_pngg/chapter4_4310.asp#4420</p>
In home Dependency	<p>Children ages 0-5 years require two in-home visits every calendar month for the first 120 calendar days of an established in-home dependency. One visit each month thereafter. <i>(This applies to ICPC sending and receiving cases).</i></p> <p>Children ages 6-18 require one visit each calendar month.</p>	All (100%) visits must occur in the home where the child resides.	<p>Social worker must document H&S visit with child within 7 calendar days of the visit, using the following code:</p> <ul style="list-style-type: none"> • Child - H&S Monitoring Visit (CA Social Worker) value/code • Child – H&S Monitoring Visit (Conducted by Other Agency) <p>Social worker visits with parent /caregiver must be documented using the following code:</p> <ul style="list-style-type: none"> • Monthly Caregiver Contact (in-Person) and ensure the correct child(ren) (i.e. participants) is/are selected <p><i>Courtesy Supervision Social Worker will complete the H&S visit(s) and documentation requirements.</i></p>	<p>For children ages 0-5 that require two visits a month, one of the two visits may be conducted by a CA paraprofessional or contracted provider.</p> <p>Policy Link: http://www.dshs.wa.gov/ca/pubs/mnl_pngg/chapter4_4310.asp#4420</p>
CA Dependent Children in	One contact each calendar	JRA facility or by	Social worker must document H&S visit with child	<i>This is the only population for which a</i>

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Program and Practice Improvement
April 2010

Case Type	Frequency of Visits	Location of Visit	Documentation Requirements	Other Clarifications
JRA Institution	month. Contact may be by telephone or in-person with JRA counselor and dependent youth.	telephone	<p>within 7 calendar days of the visit, using the following code:</p> <ul style="list-style-type: none"> ● Child - H&S Monitoring Visit (CA Social Worker) value/code (for in-person visit) ● Child – H&S Monitoring Visit (Conducted by Other Agency) value/code (for telephone contact with youth) <p>Social worker visits/contacts with JRA counselor must be documented using the following code:</p> <ul style="list-style-type: none"> ● Contact-Care Provider or Facility Provider Contact value/code (for telephone or in-person visit) <p><i>Courtesy supervision cannot be requested for this population</i></p>	<p><i>telephone contact counts as a monthly visit.</i></p> <p>Consider the following when determining if an in-person visit should occur:</p> <ul style="list-style-type: none"> ● Current needs of the youth based on consultation with the JRA counselor and youth. ● Legal status of the youth. ● Involvement of the youth's family. ● Contact with other significant adults outside the facility. ● Permanent plan and necessary steps to achieve it. ● Length of time until discharge, with particular consideration given to attendance at the Pre-Release Transition Planning meeting <p>Policy Link: http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4310.asp#4420</p>
CA Youth Transitioned Out-of-Care and Remain in Placement (i.e., 18 to 21)	Every 90 days – contact or visits	No requirements	<p>Social worker must document within 7days, using the following codes:</p> <ul style="list-style-type: none"> ● Transitioned Youth/Adult - H&S Monitoring Visit (CA Social Worker) value/code <p>Document in the notes how the youth/adult is progressing in his/her Voluntary Plan and following the terms of the Continued Placement Agreement.</p>	<p>Policy Link: http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/Chapter4_4300.asp#4307</p>

April 2010 Update
Children's Administration & School District Interagency Agreements

OSPI Data: 2008 Annual Report on Students in Foster Care

More Than 100 Students in Foster Care in School Year– 2006/2007

School District	Number of Foster Youth	School District/CA Agreement signed
Bethel School District	157	Yes
Clover Park School District	108	Yes
Everett School District	150	In process
Evergreen School District	113	Yes
Federal Way School District	116	Yes
Highline School District	168	Yes
Kent School District	104	Yes
Marysville School District	122	Yes
Mukilteo School District	102	In process
Renton School District	102	Yes
Seattle Public Schools	445	Yes
Spokane School District	384	Yes
Tacoma School District	261	Yes
Vancouver School District	208	Yes
Yakima School District	162	Yes

Youth in schools with signed agreements = 2450

Youth in schools without signed agreements = 252

Total = 2702

Percentage of youth in schools with agreements = 91%

Percentage of youth in schools without agreements = 9%

More Than 50 Students in Foster Care in School Year – 2006/2007

School District	Number of Foster Youth	School District/CA Agreement signed
Aberdeen	71	Yes
Arlington	60	Yes
Auburn	90	Yes
Battle Ground	66	Yes
Bellingham	69	Yes
Bethel	157	Yes
Bremerton	74	Yes
Central Kitsap	95	Declined
Central Valley	96	Yes
Clover Park	108	Yes
Edmonds	79	No
Everett	150	In process
Evergreen	113	Yes
Federal Way	116	Yes
Highline	168	Yes
Issaquah	59	In process
Kennewick	89	Yes
Kent	104	Yes
Longview	62	Yes
Marysville	122	Yes
Moses Lake	91	Yes
Mt. Vernon	55	Yes
Mukilteo	102	In Process
Pasco	62	Yes
Port Angeles	63	Yes
Puyallup	86	Yes
Renton	102	Yes
Richland	50	Yes
Seattle	445	Yes
Sedro Woolley	59	No
South Kitsap	77	Yes
Spokane	384	Yes
Tacoma	261	Yes
Tumwater	51	No
Vancouver	208	Yes
Yakima	162	Yes

Youth in schools with signed agreements = 3611

Youth in schools without signed agreements = 595

Total = 4206

Percentage of youth in schools with agreements = 86%

Percentage of youth in schools without agreements = 14%

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**INTERAGENCY AGREEMENT
BETWEEN
DIVISION OF CHILDREN AND FAMILY SERVICES - Region 5
and
FIFE SCHOOL DISTRICT #417
REGARDING
EDUCATIONAL STABILITY FOR CHILDREN IN FOSTER CARE**

This Interagency Agreement ("Agreement") is entered into between the Region 5 Division of Children and Family Services (DCFS) of the Children's Administration (CA), within the Washington State Department of Social and Health Services (DSHS), and the Fife School District for the purpose of promoting educational stability for children in foster care who are enrolled in schools within the School District, pursuant to RCW 74.13.550 – 74.13.570.

Fife School District	Dr. Steve McCammon
Address	5802 20 th St. E, Fife, WA 98424
Telephone	(253) 517-1000
Liaison	
DCFS	Nancy Sutton, Region 5 Administrator
Address	1949 South State Street, (MS N27-1) Tacoma, Washington 98405-2850
Telephone	253-983-6260
Liaison	Gary Fontaine 253/983-6251 foga300@dshs.wa.gov

This Agreement incorporates certain elements previously established by the *Protocol for Development of Interagency Agreements between DCFS and School Districts*, as follows:

I. General

A. Purpose

The parties acknowledge and support the intent of RCW 74.13.550 that children placed into foster care shall remain enrolled in the schools they were attending at the time they entered into temporary foster care, whenever that is practical and in the best interest of the child. Further, the parties agree to coordinate services to children in foster care in order to improve their educational outcomes.

B. Confidentiality

The School District shall ensure that confidential information regarding a student will be protected from viewing or access by persons who have no direct role in case planning for the student.

C. Planning

DCFS Regional Office and the School District shall each identify a liaison for system issues who will have responsibility to problem-solve issues and to refer policy concerns to administration for resolution. Individual child concerns are handled by the DCFS assigned social worker and the school identified liaison for child planning activities. See Section IV.

II. School District Responsibilities

A. Service Planning

The School District agrees to:

1. Maintain a stable academic placement for the child when it is in the best interest of the child and can be reasonably accomplished.
2. Participate in a timely, collaborative effort with a DCFS representative and the foster or relative care giver to determine if it is in the best interest of a child in a temporary foster care placement to maintain a stable educational environment by attending their school of origin.
3. Consider the following information or data as part of this collaborative planning effort: safety concerns, wishes of the child, wishes of the parent, anticipated length of stay in temporary foster care, proposed permanent living arrangement, geographic location of the placement, length of travel time from the placement to school, available transportation resources, attendance history, grades, after school activities, temporary housing, and any other information that would assist in a making a sound education decision that is in the best interest of the child.
4. Facilitate expedited enrollment to reduce out of school time for children in foster care.
5. Assist in developing a transition plan with a DCFS representative and foster or relative care giver for the student who is changing schools when it is determined that it is not practical for the child to remain in the school of origin.
6. Participate in educational planning on behalf of the foster child remaining in the school. This includes inviting the DCFS social worker, caregiver, CASA/GAL and parents (when they maintain legal custody and unless contact is restricted by the court) to any meetings scheduled to discuss

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the educational needs of the child. The participants invited may vary as needed to develop educational plans and respond to safety concerns.

B. Information Sharing

The School District agrees to:

1. Develop a plan/protocol for the transmission of education records to CA within 2 school days of request as required by RCW 28A 150.510. ("In order to effectively serve students who are dependent pursuant to chapter 13.34 RCW, education records shall be transmitted to the department of social and health services **within two school days** after receiving the request from the department provided that the department certifies that it will not disclose to any other party the education records without prior written consent of the parent or student unless authorized to disclose the records under state law. The department of social and health services is authorized to disclose education records it obtains pursuant to this section to a foster parent, guardian, or other entity authorized by the department to provide residential care to the student.")

C. Transportation

The School District agrees to develop transportation plans as follows:

1. If the decision is to have the child remain at his or her school of origin and the child would still **live within** the current school district's boundaries during temporary placement, then a cooperative transportation plan will be developed between the district, the caregiver and DCFS representative.
2. If the decision is to have the child remain at his or her school of origin and the child would **reside outside** of the school district's boundaries during temporary placement, then a cooperative transportation plan should be developed by the two school districts, the caregiver and the DCFS representative.
3. When a student in foster care qualifies as "homeless" under the federal McKinney-Vento Act, use the principles contained in the Act and subsequent local agreements to provide for transportation. (By definition of the federal McKinney-Vento Act, 42 U.S.C. § 11434A (2) (A) and (B) (i), students awaiting foster care placement are considered homeless. These students are to be afforded all of the rights and protections of the McKinney-Vento Act as outlined in law.)

D. Training

The School District agrees to:

1. Work collaboratively with DCFS to provide on-going and current information and cross-training about the services that are provided by

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both organizations for our foster care children and their care providers.

2. Provide information and training for teachers, administrators, counselors, transportation coordinators, homeless student liaison, and any other staff concerning the unique needs and educational rights of children in foster care, in order to remove barriers and to improve educational achievement for foster children.
3. Training may be coordinated through the local school district or through the educational services districts which serve multiple school districts.

E. School based recruitment for foster homes

The School District agrees to:

1. Work collaboratively with DCFS, the Division of Licensed Resources and foster recruitment contractors to permit recruitment for foster homes at appropriate school district meetings and events.
2. The school district will permit educational information to be distributed about the need for foster homes within the district.

III. DCFS Responsibilities

A. Service Planning within DCFS

DCFS agrees to:

1. Information Sharing:

- a. Promptly notify the original school district that a child enrolled in a district school has been placed in foster care. This will be referred to as a "placement notification call."
- b. Contact the school the child attends to provide an update within a few days of placement. This includes providing a copy of the shelter care order or voluntary placement agreement as well as emergency contact information and information about who can have contact with or pick the child up from school.
- c. For placement changes after the initial placement into foster care: DCFS agrees to promptly notify the school that the child has had a planned or unplanned change in placement. DCFS will provide a current caregiver name, address and phone number. The foster or relative caregiver will contact the school for start and dismissal times.

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2. Planning:

- a. Participate with the school district and foster or relative caregiver in a timely, collaborative effort to assess, on a child specific basis, whether and how to maintain stable school placement during temporary foster placement. Follow process outlined in II.A.3. of this agreement.
- b. Participate in timely educational planning with the school on behalf of the child in foster care. This includes sharing sufficient case information to allow the school to make appropriate safety and educational decisions on behalf of the child. Examples of information to be shared include: child's legal status, living arrangements, name and address of foster or relative caregiver, results of any developmental or health screening that would have an impact on education, names of persons authorized to pick up child from school, any threats to child safety, copies of any restraining orders, potential threats by the foster child to other children, name and method of contact for assigned Guardian ad litem (GAL) or Court Appointed Special Advocate (CASA), other relevant case information.
- c. Include information from the school in the child's initial DCFS health and education screening and in the development of DCFS service plans for the child.
- d. Invite school participation in a Family Team Decision Making (FTDM) meeting if one is held (usually prior to or just after a placement). Invite school participation in the Dependency Case Conference (held 30-45 days after placement) if one is held. School personnel may join the case conference in person or by telephone conference call.

3. Training:

- a. Work collaboratively with the Resource Family Training Institute to ensure that the importance of educational services and advocacy for foster children is incorporated into initial and continuing education for foster parent or relative care givers.
- b. Work collaboratively with the school district to provide information and cross-training about the roles, responsibilities and services of both organizations in regard to foster children and their care providers. Training may be coordinated through the local school district or through the educational services districts which serve multiple school districts.
- c. Provide on-going information and training for social workers and case aides on the importance of stable educational services and the need for collaboration with schools to improve educational outcomes for foster children.

B. Transportation

DCFS agrees to:

1. Instruct foster or relative caregivers to continue the foster child's enrollment in the school of origin, at the time of placement, whenever practical and in the best interest of the child.
2. Facilitate the foster child's continued attendance at the school of origin during the first few days of foster care placement until a transportation plan is finalized for the child. This includes encouraging transportation of child by caregivers to the school of origin, and authorizing payment of mileage for school transportation to the foster or relative caregiver.
3. Participate in a collaborative effort with the school district and foster or relative care giver to determine whether it is in the best interest of a child who is in temporary foster care placement to maintain a stable educational environment by attending their school of origin.
4. Address the foster child's school enrollment information on the Child Information and Referral Form (DSHS Form 15-300)
5. Seek volunteers to provide transportation with mileage reimbursement if needed.
6. Determine whether the child is eligible for federal funding participation for transportation costs under 42 U.S.C. § 675.

C. Recruitment and Placement

DCFS agrees to:

1. Schedule foster home recruitment events within the school district and actively recruit potential foster parents who would be willing to be a resource to children within the school district. Develop and distribute educational materials about the need for foster homes within the district.
2. Develop a method to identify foster homes by school district and make an effort to first place a child in a suitable foster home within the district, if one is available. (Suitable relative placements outside the district will take priority over a foster home within the district.)

IV. Identified Liaisons and Contact Persons

The following contact persons are identified as necessary for the smooth implementation of student case planning decisions and for the resolution of identified policy or system concerns:

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A. Contact person for placement notification calls:

1. DCFS: Unit secretary or Customer Service Specialist for the local office placement unit.
2. School District: _____

B. Liaison for child planning activities. These individuals will work collaboratively to assess whether it is practical and in the best interest of the child to remain in the school of origin. They will collaboratively develop transportation plans or transition plans for each child.

1. School District: _____
2. DCFS: Assigned social worker
3. CASA/GAL (when appointed)

C. Liaison for policy and system issues. These individuals will work collaboratively to resolve, at the lowest possible level, policy concerns, training issues, or system coordination problems identified by the student, caregiver, parent, contact persons, or liaisons for child planning activities.

1. DCFS: Gary Fontaine, Deputy Regional Administrator
2. School District: _____

IV. Resolving Disagreements

- A. Every effort will be made to resolve disagreements at the level closest to service delivery for the student.
- B. The guiding principle for reaching agreement will be the best interest of the child.
- C. The school district and the department agree to be responsive, flexible and timely in engaging with each other to resolve issues.
- D. Both parties are free to consult informally, as needed, with other resources such as the Educational Services District, Superintendent of Public Instruction, Children's Administration state office or Office of the Attorney General.
- E. The following process will be a general model for resolving disagreements.
 1. The DCFS social worker and supervisor will work with the identified liaisons as well as school building identified representatives (could be a counselor, social worker, principal and/or homeless services liaison) to resolve issues. If no agreement:
 2. The social worker, supervisor, Area Administrator and/or DCFS Education Coordinator will work with building representatives as well as district office

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representatives. (Depending on the issues this could include a representative from the transportation department, special education services, guidance services, services to homeless students, or others). If no agreement:

3. The DCFS Deputy Regional Administrator and the School Superintendent or designee will reach a resolution.

F. For students eligible for the protections of the McKinney-Vento Act, disputes involving enrollment will follow the statewide dispute resolution procedure developed by the Superintendent of Public Instruction and distributed as Bulletin 049-04, August 10, 2004. .

V. Additional Specialized Services

Any individualized or specialized services in addition to the above that may be agreed to between the parties for a specific school district, school, or enrolled foster child shall be as listed below, or as set forth in an exhibit or attachment to this Agreement.

VI. Additional Terms

A. Term of Agreement

This Agreement shall begin as of the date of signing of the Agreement by both parties and shall continue until terminated at the discretion of either party.

B. Periodic Review

The parties agree to review periodically this Agreement; to review whether the purposes and objectives of this Agreement have been met. This review shall occur minimally every two (2) years.

The Agreement may be modified by written agreement.

C. Funds

The parties acknowledge that no funds are transferred under this Agreement, and that this Agreement is for collaboration purposes only.

D. Confidentiality

Neither party shall use or disclose any information concerning any foster child enrolled at a school or otherwise affected by this Agreement for any purpose not directly connected with the administration of the party's responsibilities under this Agreement except as otherwise specifically permitted by law.

E. Applicable Federal Laws

Ensure Free and Appropriate Public Education (FAPE) is provided consistent with state and federal requirements and that children/youth with disabilities are provided appropriate Individual Education Plans (IEP) under IDEA

