Center for the Study of Social Policy

September 6, 2016

Via Electronic Mail

The Honorable Thomas F. Hogan
U.S. District Court for the District of Columbia
E. Barrett Prettyman U.S. Courthouse
333 Constitution Avenue, NW, Room 4012
Washington, DC 20001
thomas_f._hogan@dcd.uscourts.gov

Re: *LaShawn A. v. Bowser*, Civil Action No. 89-1754 (TFH)
Interim Status Report

Dear Judge Hogan:

At the status hearing on June 21, 2016 to review the District of Columbia's progress in meeting the requirements of the *LaShawn A. v Bowser* Implementation and Exit Plan during the July through December 2015 monitoring period, the Court scheduled an interim status hearing for September 9, 2016 to receive updates from parties about concerns raised in several areas of the District's performance. Specifically, concerns about lack of progress in meeting performance requirements within child protective services (CPS), the appropriate placement of children in foster care and case planning and services for children and families were raised at the June 21 hearing and in the Monitor's *LaShawn A. V. Bowser Progress Report for the Period July 1 – December 31 2015* to the Court.

The Monitor is providing this letter in advance of the September 9 interim status hearing to provide more recent performance data for select Exit Standards for which validated data are currently available for the months of January through June 2016[1] as well as updates on the District's implementation to date of planned strategies related to these areas.

A. Child Protective Services

1. *Caseloads* (IEP citation I.D.25.)

While conducting monitoring activities for the July through December 2015 period, the Monitor received reports from CPS investigation and family assessment (FA) workers citing concerns with the way in which caseloads were managed and case assignments were documented in FACES.NET. After verifying these reports, the

[1] In some instances, data from July 2016 are referenced.

Monitor determined that investigation and FA caseload data for that period was not valid and could not be reported on by the Monitor.

In April 2016, the Monitor shared these concerns with CFSA leadership and they quickly responded and took steps to ensure that these practices are no longer occurring. However, as these problems were occurring in April and May 2016, the Monitor is not able to validate or report CPS caseload data for January through June 2016. The Monitor is currently working with CFSA to ensure the reliability and validity of CPS caseload data as reported and analyzed through FACES.NET with the expectation of being able to report accurate caseload information for the July through December 2016 monitoring period. Below are the activities the Monitor plans to undertake over the next several months to ensure that caseloads are accurately counted:

- Collaboration with CFSA on development of a new FACES.NET management report for CPS investigation and FA caseloads that looks at individual worker caseloads each day and produces average daily caseloads for each worker during a month.

- Monitor staff validation of caseload assignment practices and CPS investigation and FA caseloads through confidential phone surveys to a sample of workers in September and October 2016.

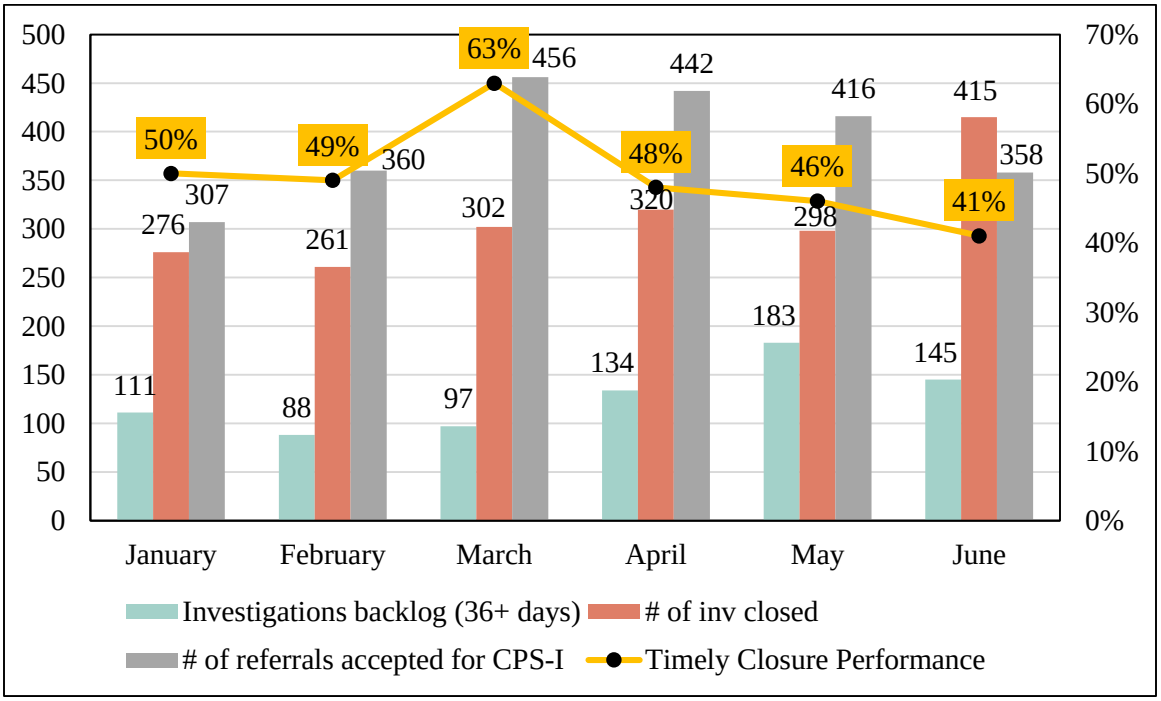
2. *Timely Closure of Investigations* (IEP citation I.A.1.b.)

Between January and June 2016, a monthly range of 41 to 63 percent of investigations that were completed each month were closed within 35 days of the report to the hotline (see Figure below). Performance peaked in March 2016 but declined in the following months, with the lowest performance in June 2016. This low performance was anticipated by CFSA as they were taking numerous steps to improve the quality of investigative practice and they did not have a sufficient number of workers in CPS to handle the workload. The most current performance data available is for July 2016 during which 50 percent of investigations closed within 35 days, still significantly below the IEP Exit Standard requirement of 90 percent.

Given that the steps required to improve performance include adding and training additional workers, improving supervisory reviews and management practices and improving barriers such as the need for additional cars and access to information about families when they cannot be easily located, the Monitor did not expect to see improvement in this period. Rather, we think that CFSA is taking concrete steps to

improve the quality of practice, the demands on individual workers and ultimately the performance on timeliness. If their efforts are successful, CFSA expects to be able to document demonstrated improvement in the months ahead.

Additional data analysis by the Monitor factoring in the number of new investigations opened, number of investigations closed and number of investigations in backlog status (meaning open more than 35 days) each month provides further understanding of the factors impacting performance. The backlog fluctuated each month this monitoring period, with a low of 88 investigations as of February 29, 2016 and a high of 183 investigations on May 31, 2016. As of June 30, 2016, the backlog included 145 investigations but by July 31, 2016, the number dropped to 96 investigations as a result of intensive and ongoing efforts by CFSA staff to review and complete overdue investigations. As displayed in the Figure below, the substantial increase in the number of investigations closed in June 2016 coincided with the lowest monthly performance for timely closure. These data reflect CFSA's efforts to target and close overdue investigations, which mean that the percentage of referrals closed timely during the month will be lower.



Source: CFSA Administrative Data, FACES.NET reports INT003, INV002 and INV004

3. *Update on Strategies within Entry Services (CPS Investigations and Family Assessment)*

The *LaShawn* 2016 Strategy Plan includes numerous strategies targeted toward CPS to improve performance on the Exit Standards pertaining to timely initiation[2], timely closure and quality of investigations[3]. CFSA provided the Monitor with a status report on implementation of these strategies as of August 15, 2016. A full assessment will be included in the next monitoring report but several highlights are included below:

CFSA managers and staff from Agency Performance (AP) completed an assessment of CPS data including trend studies and shift-to-shift reports to identify gaps or delays in tasks which may result in investigations not being initiated in a timely manner. CPS operates 24 hours a day, with workers available on three separate shifts. For some referrals, one worker may be tasked with initiating a response and the referral is later assigned to the ongoing caseload of an investigator on another shift. Through a focus group and business mapping process completed in May 2016, CFSA identified several factors which have the potential to impact timely initiation of investigations including: the number of workers available on each shift; a shortage of available cars; competing tasks for social workers (i.e., responding to an investigation requiring immediate response will redirect the investigator's planned work for that shift); hotline data entry delays; and supervisor availability to review calls and determine the investigation pathways and next steps. The longest delay was occurring between the time a referral was received by the hotline and approved by the hotline supervisor to when it was reviewed by the Hotline R.E.D. Team for pathway decision making. This process was sometimes taking up to 15 hours, making it impossible for workers to meet investigation initiation timeframes. CFSA developed an action plan with corresponding strategies to address these barriers including:

- Adding an additional CPS investigation unit by converting and permanently moving one day time FA unit into a day time CPS investigation unit. The conversion occurred in late-August 2016. In addition, this fall, CFSA will be adding two new day time CPS investigation units consisting of one supervisor, five social workers and one family support worker (FSW) each. Recruitment efforts are ongoing for additional workers and needed supervisors.

- Amending the weekend coverage schedule to ensure that the staffing on the weekend includes two full units with both CPS investigation and FA staff. Due to

[2] Performance data for timely initiation during this monitoring period were not validated in time for this interim report.
[3] Performance data for quality of investigations were not finalized and validated in time for this interim report.

notification required to staff and the union, this change was not effective until the end of August 2016.

- Modifying the referral assignment distribution process. In the past, cases were assigned on a rotating schedule to units to then be assigned to workers by unit supervisors. The change beginning at the end of August 2016 is that referrals will be assigned to individual workers by administration managers after taking into account individual worker caseloads as well as factors including workers on medical or planned leave and individual caseload management needs.

- Modifying the Hotline R.E.D. Team process so that fewer reports go through the Hotline R.E.D. Team and those that are less complicated can be immediately assigned to workers for action. Beginning in June 2016, the Hotline R.E.D. Team reduced the number of meetings from three to one per day. As a result, Hotline R.E.D. Teams are now used for referrals with one or more of the following criteria: families with four or more referrals with the most recent referral occurring in the last 12 months; families with three or more referrals within a year; families with existing open in-home or out-of-home cases; referrals with other complicating matters or grey areas impeding the decision making process; and families with chronic neglect.

- Adding two vehicles to CFSA's fleet with two additional vehicles scheduled to be added by the end of September 2016.

4. *Review of Decision Making for Hotline Referrals*

In early 2016, the Monitor and CFSA staff worked collaboratively to review pathway decisions made for referrals to CFSA's hotline. The review focused on referrals that were screened out at one of three entry points: either by 1) hotline staff, 2) CFSA's Educational Neglect Triage Unit or 3) during a Hotline R.E.D. Team. The Hotline R.E.D. Team portion of the review assessed not only screen-outs but any pathway decision made for referrals presented including a CPS investigation with a 24 hour response time, FA with a three day response time and FA with a five day response time.

The review assessed a sample of referrals at each entry point using structured instruments and trained reviewers. Data from the review determined that of the 291 referrals reviewed (including recorded calls, faxes, emails and decisions made through the Hotline R.E.D. Team), reviewers agreed with the decision made to either screen out the referral or agreed with the pathway decision made at the Hotline

R.E.D. Team in 77 percent (N=225) of the referrals and disagreed with 23 percent of decisions. Reviewers disagreed with a decision to screen out a referral due to a worker diverging from CFSA protocol in 12 percent (N=34) of the referrals. Reviewers disagreed with the decision in instances where workers followed CFSA protocol but reviewers disagreed with the decision that was made in an additional 11 percent (N=32) of the referrals reviewed.

Data analysis was also conducted on only the screen out decisions. There were 223 referrals screened out at the hotline, or by the Educational Neglect Triage Unit or the Hotline R.E.D. Team. Of the 223 referrals in the sample of screen outs, reviewers agreed with the decision to screen out the referral in 73 percent (N=163) of the referrals reviewed. Of the 60 referrals where reviewers did not agree with the screen out decision, 14 percent (N=35) involved workers not following CFSA protocol while the remaining 13 percent (N=25) represented referrals where the reviewer disagreed with the decision was made even though protocol was followed.

Strengths in practice identified during the review include the following:

- **Hotline workers demonstrate positive customer service practices in the majority of interactions with callers.** Specifically, 82 percent of hotline workers maintained positive customer interaction, 78 percent of workers used a pleasant and inquisitive tone and 74 percent of workers paid attention to the reporter's emotions. Additionally, 72 percent of workers asked clarifying questions.

- **The reporter's name and phone number were collected for 92 percent of the referrals.** While it is acceptable for a caller to remain anonymous and the hotline by policy will accept anonymous reports, a call back number allows the hotline worker to reach the reporter if the call is dropped or if more information is needed and, if the referral is assigned to a social worker, it allows the assigned worker to more easily follow up with the reporter for additional context and details.

- **CFSA has largely institutionalized the R.E.D. Team framework in its intake operations.** The review highlighted the deliberative steps that are built into the intake process across all entry points and demonstrate the system's approach to review, evaluate and direct each referral to the appropriate pathway.

- **There is evidence of supervisory involvement and review of intake decisions by the Educational Neglect Triage Unit and at the Hotline R.E.D. Team.** The designated supervisor reviewed the Educational Neglect Triage Unit workers' recommendations for every educational neglect referral in order to determine the final screening decision. Additionally, supervisors were present for discussions of

each of the 96 referrals reviewed at the Hotline R.E.D. team meetings observed by reviewers.

Areas needing improvement include:

- **Reviewer disagreement with the decision to screen out a referral in approximately one-fourth of the referrals reviewed demonstrates a need for improved reliability and consistency of decision making.** Common reasons for disagreement with the screening decision included accuracy of documentation and lack of thorough information gathering and analysis, both of which are critical parts of a well-informed, clinically-based pathway decision on a report of alleged abuse or neglect.

- **There are gaps in hotline workers' practice of gathering information which can be critically important when making a decision involving a child's safety.** In 80 percent of all referrals screened out at the hotline, the written narrative did not include specific details of the home environment which is essential to assessing the safety of the child. Of the decisions assessed to screen out a referral, reviewers found that reflective listening occurred in only 23 percent; use of exception questions was found in 18 percent; and in only 20 percent of the referrals did the hotline worker summarize the reporters concerns prior to ending the call.

- **Reviewers found that hotline workers did not consistently document information shared by callers in an accurate manner.** Reviewers listened to the recorded hotline calls and compared it with the documentation in FACES.NET which is the primary source of information used by supervisors and the Hotline R.E.D. Team when making a decision to screen a referral out or assign it for investigative or FA response. In almost one-third (30%) of the referrals screened out at the hotline, reviewers determined that either specific details provided by the reporter were not written in the narrative or there were specific details included in the documentation that were not provided by the caller.

- **School reports of educational neglect are not routinely entered into FACES.NET in a timely manner.** When calls are made to the hotline, FACES.NET automatically enters the time that the call was received and CFSA is responsible to initiate referrals that are assigned as investigations and FA within a specific timeframe that begins when the call was received. Educational neglect referrals are submitted by schools utilizing an automated form transmitted electronically to the Educational Neglect Triage Unit. The Educational Neglect

Triage worker subsequently enters the referrals into FACES.NET and the required timeline and tracking of that referral does not begin until the referral is entered into FACES.NET. The review found that there were significant delays between a referral coming from a school and the date it was entered into the system for action. Thirty-six percent of school reports were entered into FACES.NET within 24 hours, an additional nine percent within 48 hours and the remainder (55%) in three to 22 days from the receipt of the report from the school.

- **Improvements are needed to ensure consistent follow up on educational neglect referrals that are screened out based on exisiting child welfare involvement due to there being an already open in-home case, investigation or FA for the family.** CFSA policy provides that when an educational neglect referral is screened out because there is a currently open investigation or FA, communication must occur with the assigned CFSA worker so they are notified that the school submitted a report of possible educational neglect. However, of the 23 referrals that were screened out for these reasons, there was evidence of the required follow-up with the ongoing worker, FA worker or investigator in only 65 percent of the applicable referrals (15 referrals).

- **Inconsistencies were found between the information provided by the school in their educational neglect report and the referral information entered into FACES.NET which is what CFSA supervisors use to approve pathway decisions.** In general, the Educational Neglect Triage Unit is likely to screen out a referral when the school (who by law has to report children who have 10 or more unexcused absences) reports that the student's attendance issues have not had a negative impact on academic performance. However, reviewers found multiple instances (12 referrals) where the Triage Unit screened out a referral for that reason even when the report from the school specifically stated that the there was a connection between the absences and the child's educational performance.

- **The quality of facilitation of R.E.D. Team meetings was variable and makes a difference in its effectiveness.** The protocol requires that the facilitator guides the discussion and assists the team in processing the information. While reviewers observed examples of excellent facilitation, for 36 percent of the referrals reviewed, improvements in facilitation were needed to enable and support stronger analysis. Further, reviewers noted that some meetings relied too heavily on speculation and that the analysis of key data was sometimes superficial.

- **The Consultation and Information Sharing Framework (CISF) and genogram are not used with full fidelity.** The R.E.D. Teams use a structured Consultation and Information Sharing Framework to guide their discussion and

analysis. The use of genograms which identify all family and related relationships is a required element. Within the CISF, reviewers noted confusion between the *complicating factors* and *grey area* sections. Reviewers also found that family genograms were correctly used for slightly more than half (58%) of referrals.

The Monitor and CFSA completed a report which includes a more detailed analysis of the data, strengths in practice and areas needing improvement which is attached to this letter. Recommendations from the review and plans for further continuous quality improvement are being discussed between the Monitor and CFSA and will be finalized in the next two weeks.

B. Placement

The Monitor's report for the period July – December 2015 identified the appropriate placement of children as an area of concern, citing numerous problems reflecting gaps in the placement array and placement matching process. CFSA has been working since last year to alleviate these problems, including taking steps to ensure that children are not again staying overnight in the CFSA office building or in hotels.

1. *Placement of Children in the Most Family-like Setting – no overnight stays at CFSA building or hotel* (IEP citation II.B.8.)

The *LaShawn* standard is that no child stay overnight in the CFSA building or in a hotel while awaiting placement. In both March and August 2016, two separate older youth stayed overnight at CFSA. Placement options were offered to these youth but they declined to utilize them.[4, 5]

In July 2016, two children (in one sibling group) were removed after midnight and were at the CFSA building while awaiting placement. One child was placed around 8AM. The other child was wheelchair-bound and required a specialized medical placement, which made identifying a placement more difficult given CFSA's current capacity. He was placed later that evening after a medical evaluation.

[4] The youth who experienced an overnight stay in March returned to CFSA after having been in abscondance status. The youth's previous placement was no longer available and a temporary placement in an emergency, short-term group home was identified. The youth declined this placement and was brought back to the agency overnight. Upper level management and administrators were not notified of the situation as it was occurring as is CFSA's protocol. The youth was later placed at her previous group home placement.

[5] The youth who experienced an overnight stay in August arrived at the agency in the afternoon after experiencing a placement disruption. An acceptable placement was difficult to secure due to the youth's challenges, his desire to not be in placement and the ability for identified foster parents to meet his needs. CFSA engaged the youth's birth family and Office of Well-Being to support the transition to a new placement the next day where the youth remains today.

2. *Update on Strategies within Placement Services*

In accordance with the *LaShawn* 2016 Strategy Plan, CFSA has identified a range of strategies to improve performance on placement standards. Highlights of the current status of implementation include:

- CFSA had planned to have the Placement Matching system in FACES.NET operational by May 31, 2016, however this has been delayed by several months as the system required a review and data cleanup of CFSA and private agency foster homes. CFSA expects to have the system functional during September 2016 and the Monitor plans to observe the process this month.

- CFSA has continued to engage in outreach and recruitment efforts to increase the supply of available foster parents. Between January and June 2016, CFSA reports partnering with 170 organizations including faith-based, government providers, schools, hospitals, the police department, youth organizations, DC cable and TV and homeowners associations to recruit foster parents. CFSA has also utilized social media platforms and partnered with the CFSA Youth Ombudsman and DC Foster and Adoptive Parent Association to organize and host a recruitment event in April 2016 with over 20 youth, foster care alumni and current or potential resource parents.

- As a result of CFSA's recruitment strategies, 23 foster homes, with a capacity to accommodate 41 children, were opened between January and June 2016.

3. *Resource Development Plan* (IEP citation I.D.23.)

CFSA submitted the FY2017 Resource Development Plan (RDP) to the Monitor on June 29, 2016. The RDP is intended to project the number of placements required during the upcoming year and identify strategies to assure that CFSA has a sufficient number of appropriate placements available. Both the Monitor and Plaintiffs' counsel have reviewed the RDP and provided feedback and questions to CFSA. A joint discussion was held on August 11, 2016 to discuss Plaintiff counsel's feedback. CFSA shared a revised draft RDP with the Monitor on September 2, 2016.

C. Provision of Services and Case Planning

The Quality Service Review (QSR) is a case-based qualitative review process that includes interviews with all of the key persons who are working with and are familiar with the child and/or family whose case is under review. The QSR is used to assess

areas of strengths and challenges related to the status of the child and family and system performance. The QSR is used to measure two *LaShawn* Exit Standards: 1) provision of services to children and families to support safety, permanency and well-being (IEP citation I.A.3.) and 2) development of case plans in partnership with children and families that identify specific services, supports and timetables for providing needed services (IEP citation I.B.17).

Between January and June 2016, a total of 64 QSRs were completed to assess performance on the two identified *LaShawn* Exit Standards. Sixteen of the 64 QSRs were conducted on children receiving in-home services and the remaining 48 QSRs were focused on children placed in out-of-home care. Of those placed in out-of-home care, 21 QSRs were conducted on cases managed by CFSA and 27 QSRs were conducted on cases managed by the private agencies. Data on the results are provided below:

1. *Services to Families and Children to Promote Safety, Permanency and Well-Being* (IEP citation I.A.3.)

Data for January through June 2016 show a slight improvement in performance from CY2015 and for the same time period in 2015 (January through June) on indicators measuring services to families and children to promote safety, permanency and well-being. Overall performance, although still far below the required standard of 80 percent, was 39 percent in CY2015 and was 45 percent in the first six months of CY2016. Performance increased for cases managed by the private agencies (26 percent for CY2015 to 44 percent for January through June 2016). There remains a difference in performance between cases for child(ren)placed out of home and cases where the child is living in the home of their parent or guardian. For in-home cases, acceptable performance on service provision for January through June 2016 was at 31 percent, dramatically below the IEP and good practice standards.

2. *Case Planning Process* (IEP citation I.B.17.)

Data for January through June 2016 show little change from CY2015 in performance on indicators measuring the case planning process. Overall performance for January through June 2016 was 48 percent, within three percentage points of CY2015 performance of 51 percent. Similar to improvements in *Services to Families and Children to Promote Safety, Permanency and Well-Being*, there was an increase in performance in cases managed by the private agencies (37 percent for CY2015 to 48 percent for January through June 2016). All of these data indicate that performance

on case planning continues to be unacceptable and remains far below the IEP Exit Standard of 80 percent.

3. *Update on Strategies to Improve Provision of Services and Case Planning*

Between January and August 2016, CFSA has initiated activities identified in their *LaShawn* 2016 Strategy Plan both in response to QSR findings and in order to better use the data collected through the QSR process and other data available to them to inform their improvement efforts. Specifically, on the service use side, CFSA expanded eligibility for Project Connect[6] services to include families being served through in-home services. This expansion allows access to intensive support for families receiving in-home services when substance use is an identified challenge within the home.

Over the past two years, as part of efforts to infuse a trauma-informed perspective into its practice, CFSA modified its assessment tools for children and families and implemented the CAFAS/PECFAS[7] tools. The CAFAS/PECFAS are functional assessment tools for understanding the behaviors of children in different domains – including home, school and the community. The CAFAS/PECFAS assessments allow for workers to assess behaviors and behavior changes over time in response to interventions – for example therapy – and changing conditions. CFSA has recently convened a workgroup co-chaired by the Deputy Director of Operations and Deputy Director of Well-Being to assess the implementation process and effectiveness of the CAFAS/PECFAS assessment tool. The first step taken by the workgroup was to review the data on completion of assessments and discuss barriers to completing assessments every 90 days and creating behaviorally-based service plans based on the CAFAS/PECFAS assessment. Recommendations from the workgroup to improve utilization of the CAFAS/PECFAS include ongoing refresher training for workers on CAFAS/PECFAS and case planning; opportunities for increased, hands-on supervision; incorporation of clinical data to inform effectiveness of available community-based services; and regular review of CAFAS/PECFAS implementation data. This workgroup convened June 1, 2016 and is planning to meet monthly to address challenges and develop recommendations for management. CFSA also continues to work with a national expert to utilize the CISF to promote improved clinical practice throughout the agency.

[6] Project Connect is an evidence-based program designed to support families during the reunification process and in order to stabilize. The program works with parents who have a substance abuse history as the child(ren) transitions home or in cases where the child(ren) are able to remain in the home safely.
[7] Child and Adolescent Functional Assessment Scale (CAFAS) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) are functional assessment scales used to assess, track outcomes and inform case planning decisions.

> In addition, CFSA contracted with a national expert to provide technical assistance on strategies for analyzing, integrating and utilizing QSR data to understand trends in barriers to acceptable performance. The consultant provided an on-site two-day session in August 2016 to begin an assessment of the root causes behind CFSA performance on select QSR indicators and areas of practice. The national consultant will be a continued resource as CFSA moves forward in their analyses and integration of QSR data and findings with other continuous quality improvement and data review activities.

In summary, while the performance data that has been validated to date has not changed in any significant way since our last monitoring report, CFSA is engaged in tackling the problems that were identified and is taking actions in accordance with the *LaShawn* 2016 Strategy Plan. The Monitor is currently in the process of validating all necessary data for the January through June 2016 monitoring period and will file the monitoring report for that period in mid-November 2016. Please let me know if you have any questions prior to the September 9, 2016 hearing.

Sincerely,

Judith Meltzer

Judith Meltzer
Deputy Director, Center for the Study of Social Policy
Court-appointed Monitor, *LaShawn A. v. Bowser*

cc: Marcia Lowry, A Better Childhood, Inc.
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Cameron Currie, Clerk, U.S. District Court

Attachment