Center for the Study of Social Policy

Quality Service Reviews
A Mechanism for Case-Level Advocacy and System Reform

There has been increasing pressure from federal, state and tribal governments; community partners; and advocates to hold child welfare agencies accountable for the services and supports they provide to children, youth and families involved with human services systems.[1] As a result, child welfare systems, have made significant strides in increasing their capacity to collect and interpret performance-related quantitative data, such as time to permanency, number of placements children experience, percentage of children placed in family-based settings and rate of repeated maltreatment. Systems have also improved their capacity to track and report on interventions, including the number of interactions (visits, planning meetings) with children, parents and caregiver and the number of mental health, substance abuse and domestic violence treatment referrals made. Systems continue to strive to demonstrate not just ***how much*** they are doing on behalf of children, youth and families, but ***how well*** they are supporting and serving them and whether interventions are successful. It is widely recognized that the ***quality*** of work and interventions directly impacts on the well-being outcomes of children and families.

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CASE PRACTICE MODELS

*When advocates, frontline staff and administrators discuss "direct work with families," they are often referring to–either directly or indirectly–the guiding principles and expected actions to support families, or the **practice model** for the system.*[2,3]

A ***case practice model*** supports workers, supervisors, managers and administrators in understanding, performing and communicating the actions that should be taken to achieve positive outcomes for a child or youth and family. As depicted in two case practice model examples in figur 1 and 2, certain key elements or functions of case practice must be present to achieve good outcomes. The expectati is that each of these practice elements is performed in partnership with the involved children, youth, parents an caregivers. These elements include:

- *engaging children, youth, parents and caregivers* in a working relationship
- *formally and informally assessing* for strengths, protective capacities, urgent and underlying needs of children, youth and families
- *teaming* with other professionals or formal supports and informal supports
- *planning* to support goals, such as physical and emotional well-being, safety and permanency
- *effectively implementing needed supports and services*

These elements inform the actions, interventions and strategies employed by workers and their partners to achieve positive outcomes and successfully close cases. Attorneys and advocates are uniquely positioned through their interactions and relationship with their clients to recognize when these elements are working.

As advocates know, ***how well*** systems work to assess, engage, plan and support children, youth and families is critical. At the federal level, the Children's Bureau uses **Child and Family Service Reviews** (CFSRs), an interview protocol and process, with each state's child welfare system to ensure conformity with federal child welfare requirements, determine outcomes with children and families and assist states in helping children and families achieve positive outcomes.[6]

Figure 1: Case Practice Model from the District of Columbia's Child and Family Services Agency[4]

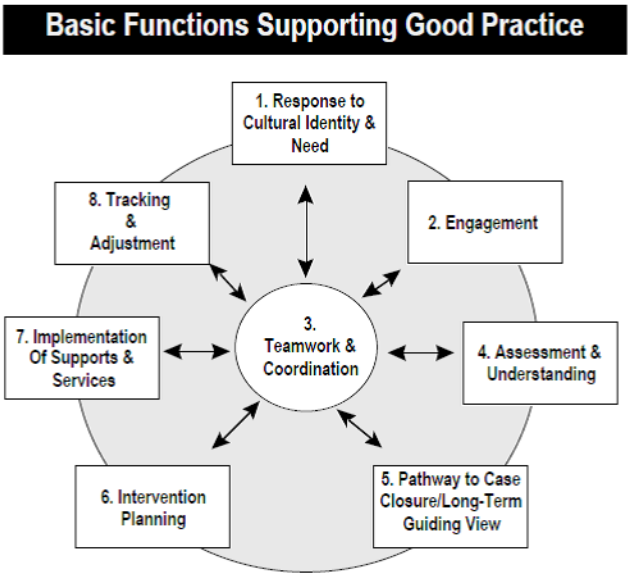

Figure 2: Case Practice Model from Children Youth and Families Division of the Victorian Government, Department of Human Services

During this review process, a select number of cases are reviewed to assess overall system performance, identify areas of strength and illuminate those needing improvement.[7,8] The results from CFSRs inform the development of system-specific Program Improvement Plans and strategies that are intended to improve overall case and system practice in the areas identified as needing improvement.

The CFSRs were loosely based on a qualitative case review system developed and implemented in Alabama's Family and Children's Services as a key component of the settlement agreement in the *R.C. v. Hornsby* (1988) class action lawsuit. This type of qualitative review continues to play a significant role in continuous quality improvement efforts for evaluating system reform and case practice in numerous states and counties across the country.[9,10]

QUALITY SERVICE REVIEWS: PURPOSE AND RELATIONSHIP TO SYSTEM REFORM

*The **Quality Service Review** (QSR), developed by Human Systems and Outcomes Inc.,[11] is a hands-on, qualitative review process that uses a jurisdiction-specific protocol to assess practices and system performance.*

QSRs provide a case-based assessment for learning and development, and the results can be used to improve outcomes for all children and families who are served by systems.[12] The QSR is being implemented in multiple jurisdictions as an element of continuous quality improvement and has the capacity to serve three key functions:[13]

① ***Clinical training for frontline workers and supervisors.*** Discussing a case while participating in the review and hearing feedback from reviewers, provides an opportunity for frontline workers and supervisors to understand how specific elements of practice are evident in an actual case. T–his form of experiential learning can then be incorporated into the current case, as well as the other cases in the worker and supervisor's purview.

② ***Norming of practice.*** A well-understood practice model and approach is central to supporting positive outcomes for the child and family. Through the QSR process of providing feedback to frontline workers and supervisors and the system's inter-rater reliability process that occurs with reviewers and quality assurance staff, there are multiple structured opportunities for deepening understanding and for

standardizing quality of practice across multiple systems. These benefits can then be transferred to a broader caseload.

③ ***Real-time, rapid assessment and data feedback.*** The qualitative data collected through the QSR process can be shared in real-time with workers, supervisors, management, administrators and the larger community. QSR data provides "the stories behind the numbers," and systems have an opportunity to quickly track and adjust initiatives and practices in response to QSR findings and the themes they reveal.

Quality Service Reviews: The Process

Each QSR is usually focused on one child or youth, selected through a stratified random sample. The process involves case file reviews and interviews with key members of the child and family's team–including immediate family members, the focus child,[14] frontline caseworkers and supervisor, service providers (including educational, mental health, substance abuse treatment, mentors, CASAs, etc.), extended family members, substitute caregivers (foster parents and congregate care providers) and attorneys (for the agency, parent and child/youth). Participation in the QSR is voluntary, and those implementing the process take steps to gain the informed consent of participants.

After the review team[15] completes the record review and interviews, team members synthesize the information to assess key indicators related to the child and family's status[16] and practice/system performance[17] (see Appendix A and Appendix B). Based on the assessment, the review team:

- assigns ratings[18] to the indicators of the child and family's status and practice/system performance
- provides feedback to the frontline workers and supervisors and helps develop next steps to build on strengths and address challenges
- meets with the quality assurance team or other reviewers to present findings from the review and ensure inter-rater reliability
- completes a redacted narrative or "child and family story" documenting the team's assessment, findings and justifying the ratings assigned

This process provides for real-time feedback and creates qualitative data and case examples that can be used to better understand strengths and challenges in case practice and system performance.

In addition to the case-specific feedback, the aggregate QSR data provides an opportunity to understand and highlight the strengths and challenges in case practice and the overall functioning of a local service system. Strengths in specific areas of practice may include, for example, a strong working relationship between mental health treatment providers and teachers. Engagement in a working relationship with birth fathers, on the other hand, may be identified as an area in need of improvement. Upon understanding both quantitative and qualitative data trends, systems can implement practice and policy enhancements, amendments or modifications to support practice improvement. Systems can also track, in real-time, the impact of those changes through subsequent QSRs.

QSRs are conducted by a team of two reviewers with a trained and "certified" reviewer in the lead role.

QSRs & Child and Family Service Reviews: Why Attorneys and Advocates Should Care

Attorneys and advocates who work for children and youth are essential members of any well-formed and well-functioning child and family team. However, they often cite a lack of coordination between the in-court work and out-of-court work as a reason for delays in moving a case forward. Whether the issue is stabilizing a child's placement with a relative by ensuring the right community supports are in place; increasing visitation between a child and his or her prospective long-term caregiver; or taking other steps to promote reunification, adoption or guardianship, attorneys rarely have the opportunity to provide current feedback to quality assurance entities in a manner that can impact a specific case, as well as system-wide practice.

Attending to ***advocacy issues***, as presented in the National Association of Counsel for Children's *Recommendations for Representation of Children in Abuse and Neglect Cases*[19] means connecting key components and expected outcomes of good case practice to the legal process. As part of the QSR process, attorneys and advocates are to be interviewed by reviewers and to offer their perspectives about the case. Reviewers want to know about the strengths, challenges and functioning of the child, family and the service systems. Attorneys should welcome the opportunity to participate in these reviews because they can:

- provide new information to reviewers that allows for the assessment of how the out-of-court work may or may not support the in-court goals
- highlight any discrepancies between the work on behalf of the child, youth and family and the desires of the child and family
- highlight strengths and gaps in collaboration with family members and other areas of case practice
- ensure that the needs of the child and parents are heard and that the safety, permanency and well-being of the client are promoted

Through participation in the QSR process, attorneys and advocates are also able to provide feedback on system-level strengths and challenges. The QSR is meant to be a mechanism for the identification of systemic trends, informed by those who regularly interact with those systems. The expectation is that honest feedback or input does not result in negative consequences for any participants.[20]

Recommendations for Attorneys and Advocates to Promote the QSR Process and Good Case Practice[21]

At the case specific level, attorneys and advocates should:

- ***Participate in QSRs when they are conducted.*** The participation of attorneys and advocates provides their unique perspectives to reviewers to inform the overall assessment of the child and family status and practice/system performance.
- ***Request a copy of the reviewer's written case narrative.*** The reviewer's written case narrative is prepared by a trained and objective reviewer who does not have a decision-making role in a case. The narrative provides specific information and a current assessment of what is going on in a case––both strengths and challenges from multiple perspectives. Reviewing and discussing this independent assessment with others involved in a case can help attorneys and advocates support their clients in achieving successful case closure or to better understand the barriers to achieving successful case closure.
- ***Ask questions directly related to the key indicators that support good case practice.*** In court and in meetings with clients and workers, attorneys should discuss activities that promote good case practice, such as teamwork and service coordination. Such questions include:
  - Do our actions reflect a pattern of effective teamwork and collaboration that benefit the child and family?
  - Is there effective coordination and continuity in the organization and provision of service across all responsible individuals and service settings?

Understanding activities that support good case practice can inform the 'asks' attorneys make of caseworkers and service providers and improve the attorney's or advocate's ability to make suggestions for next steps to support their clients[22]

At the system level, attorneys and advocates should:

- Advocate for child welfare systems to make the data collected through the QSR and CFSR available and accessible. The rigorous QSR process produces a significant amount of data that can and should be used to inform practice and policy changes and enhancements. The community–including families and professionals–deserves a well-functioning system that is transparent about its strengths and areas of challenge. Attorneys and the broader community should advocate for systems to regularly share this information as a form of accountability.
- Promote the use of QSR data to inform system-wide practice changes. The QSR process is an integral part of continuous quality improvement efforts and should be used to inform system practice changes–including identifying areas of strength that should be promoted and opportunities for improvement that should be addressed. In systems where QSRs are not currently being used, attorneys and advocates can call for their use as part of a comprehensive continuous quality improvement strategy.

ENDNOTES

1 We use the term "human services" to refer to all formal helping systems, such as child welfare, juvenile justice, children's and adult mental health, etc., that provide interventions, supports and services.

2 Vincent, P. (2012). Structuring litigation-driven child welfare reform for success. In Center for the Study of Social Policy, *For the welfare of children: Lessons learned from class action litigation* (pp. 8–19). Washington, DC: Author. Available at http://www.cssp.org/publications/child-welfare/class-action-reform/For-the-Welfare-of-Children_Lessons-Learned-from-Class-Action-Litigation_January-2012.pdf.

3 Human Services and Outcomes, Inc. (2015). *Quality service Review Protocol for a Child and Family: A reusable protocol for examination of child welfare and mental health services for a child and family. Shared practice protocol field version 2A.* A product for the District of Columbia Child and Family Services Agency and Department of Behavioral Health.

4 Human Services and Outcomes, Inc. (2015).*Quality service review protocol for a child and family: A reusable protocol for examination of child welfare and mental health services for a child and family. Shared practice protocol field version 2A.* A product for the District of Columbia Child and Family Services Agency and Department of Behavioral Health.

5 Victorian Government Department of Human Services. (2012). *Best interests case practice model: Summary guide.* Melbourne, Australia: Author. Retrieved June 30, 2015, from http://www.dhs.vic.gov.au/__data/assets/pdf_file/0008/589643/cyf_best_interests_case_practice_model_summary_guide_09_12.pdf.

6 The Children's Bureau has completed two rounds of CFSRs and began conducting the third round in all states, which will occur between 2015 and 2018.

7 Outcomes related to placement stability, permanency, connections with parents and sibling and provision of services to meet educational, physical and mental health needs are assessed.

8 A sample of approximately 65 cases of children and youth, representative of that system's child welfare population and based on key demographics, is reviewed.

9 The term "Quality Service Review" is used here but this protocol and process is known by other names. For example, it's known as the "Qualitative Review" in New Jersey and the "Community Service Review" in the Department of Behavioral Health in the District of Columbia.

10 The Qualitative Network, facilitated by Paul Vincent and Ray Foster of the Child Welfare Policy and Practice Group (CWPPG), convenes quarterly to discuss opportunities, challenges and strategies for implementing and using QSRs as part of continuous quality improvement. The Qualitative Network consists of members from across the country including (but not limited to) California, Florida, New Jersey, Indiana, Maryland, Michigan, Oklahoma, Pennsylvania, Utah, Virginia and Wisconsin.

11 Human Systems and Outcomes Inc. is now identified as the QSR Institute, a subsidiary of the Child Welfare Policy and Practice Group.

ENDNOTES

12 The Annie E. Casey Foundation and the Center for the Study of Social Policy. (2011). *Counting is not enough: Investing in qualitative case reviews for practice improvements in child welfare.* Baltimore, Maryland: The Annie E. Casey Foundation. Retrieved June 30, 2015, from http://www.cssp.org/publications/child-welfare/child-welfare-misc/Counting-is-Not-Enough-Investing-in-Qualitative-Case-Reviews-for-Practice-Improvement-in-Child-Welfare.pdf.

13 Noonan, K. (2012). Qualitative case review in a child welfare lawsuit. In Center for the Study of Social Policy, For the welfare of children: *Lessons learned from class action litigation* (pp. 49–55). Washington, DC: Author. Retrieved June 30, 2015, from http://www.cssp.org/publications/child-welfare/class-action-reform/For-the-Welfare-of-Children_Lessons-Learned-from-Class-Action-Litigation_January-2012.pdf.

14 Either an interview or observation is conducted with the focus child depending on the focus child's age and developmental stage.

15 QSRs are conducted by a team of two reviewers with a trained and "certified" reviewer in the lead role.

16 Indicators related to child and family status may include: safety, behavioral risk, stability, permanency, living arrangement, physical health, emotional well-being, learning and development, caregiver function and family functioning.

17 Indicators related to practice/system performance may include: engagement, assessment, teaming, pathway to case closure, long-term guiding view, resource availability, planning, implementation of supports and services and tracking and adjusting.

18 Ratings are on a scale of 1–6, with 1-3 being unacceptable and 4-6 being acceptable (see Appendices C and D).

19 National Association of Council for Children. (2001). *NACC recommendations for representation of children in abuse and neglect cases.* Denver: Author. Retrieved June 30, 2015, from http://c.ymcdn.com/sites/www.naccchildlaw.org/resource/resmgr/Standards/NACC_Standards_and_Recommend.pdf.

20 Reviewers are instructed to immediately report any safety or concerning risk issues to the designated leader of the review team.

21 We do not support the use of the QSR process or products in an adversarial manner.

22 Quality Service Review Protocols found at these links contain useful questions related to practice and system performance:
http://www.state.nj.us/dcf/about/divisions/opma/QualitativeReviewProtocolandInstrument.pdf
http://dcfs.co.la.ca.us/katieA/docs/QSRprotLAdtl.pdf
http://www.dss.virginia.gov/files/about/reports/children/qsr/qsr_reviews/qsr_protocol.pdf
http://www.pacwrc.pitt.edu/Resources/PA%20QSR%20Protocol%20Version%201%200.pdf

APPENDIX A

Quick Study Job Aid for Reviewers

SHARED PRACTICE PROTOCOL:
Listing of Indicators

Indicators in the Shared Practice Protocol

The Shared Practice Protocol provides reviewers with a specific set of indica- tors to use when examining the status of the child and caregiver and analyzing the responsiveness and effectiveness of the core practice functions prompted in the core practice model. Indicators are divided into two distinct domains: *child and family status* and *practice performance*.

- **Status indicators** measure the extent to which certain desired condi- tions are present in the life of the child and the child's parents and/or caregivers—as seen over a recent time. Status indicators measure constructs related to *well-being* (e.g., safety, stability, and health) and *functioning* (e.g., the child's academic status and the caregiver's level of functioning). Changes in status over time may be considered the near- term outcomes at a given point in the life of a case.

- **Practice indicators** measure the extent to which core practice func- tions are applied successfully by practitioners and others who serve as members of the child and family team. The core practice functions meas- ured are taken from the team and provide useful case-based tests of performance achievement. The number of core practice functions and level of detail used in their measurement may evolve over time as advances are made in the state-of-the-art practice.

Child/Youth & Caregiver Status Indicators

This Shared Practice Protocol provides 12 qualitative indicators for measuring the current status of a child and the child's parent and/or caregiver. Status is determined for a recent time period. A status measure is a desired outcome for a child, parent, and/or caregiver.

1. **SAFETY - Exposure to Threats of Harm.** Degree to which: • The child is free of abuse, neglect, intimidation, and exploitation by others in his/her place of residence, school, and other daily settings. • The parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm in the home and community.

2. **BEHAVIORAL RISK - Risk to Self/Others.** Degree to which the focus child: • Avoids self-harm and self-endangering situations. • Refrains from behaviors that may put others at risk of harm. *[For a child age 2 years and older]*

3. **STABILITY.** Degree to which: • The child's daily living, learning, and work arrangements are stable and free from risk of disruptions. • The child's daily settings, routines, and relationships are consistent over recent times. • Known risks are being managed to achieve stability and reduce the probability of future disruption. *[Timeframe: past 12 months and next 6 months]*

4. **PERMANENCY.** Degree to which the focus child or youth is achieving:• A good quality placement with respect to successful matching and capacity testing; •Security of positive and enduring relationships; and, where required to settle dependency, and • Resolution of legal custody.

5. **LIVING ARRANGEMENT.** Degree to which: • The child is generally living in the most appropriate and least restrictive living arrangement consistent with the child's needs for family, extended family, social rela- tionships, faith community, and culture and the child's present needs for any specialized care, education, protection, and supervision.

6. **PHYSICAL HEALTH.** Degree to which the child is: •Achieving and maintaining favorable health status, given any disease diagnosis and prognosis that the child may have; and • Receiving adequate and consistent levels of health care appropriate for the child's age and personal needs.

7a. EMOTIONAL FUNCTIONING. Degree to which: • Consistent with age and ability, the child is displaying an adequate pattern of: • Attachment and positive social relationships, • Coping and adapting skills, • Appropriate self-management of emotions and behaviors, and • Emotional functioning in daily settings.

7b. SUBSTANCE USE. Degree to which: • The youth is achieving and maintaining a life free from substance use impairment.

8a. EARLY LEARNING STATUS. Degree to which: • The child's developmental status is commensurate with age and developmental capacities. • The child's developmental status in key domains is consistent with age- and ability-appropriate expectations. *[For a child under 5 years of age]*

8b. ACADEMIC STATUS. Degree to which the youth [according to age and ability] is: • Regularly attending school, • Placed in a grade level consistent with age or developmental level, •Actively engaged in instructional activities, • Reading at grade level or IEP expectation level, and • Meeting requirements for annual promotion and course completion leading to a high school diploma, a GED, or preparation for employment. *[For a child age 5 years and older]*

9. PREPARATION FOR ADULTHOOD/PARENTING

PREPARATION FOR ADULTHOOD: Degree to which the youth [according to age and ability] is: • Gaining life skills, developing relationships and connections, and building capacities for living safely, becoming gainfully employed, and functioning successfully upon becoming independent of child services - OR - • Becoming eligible for adult services and with the adult system being ready to provide (via a seamless transition) continuing care, treatment, and residential services that the youth will require upon discharge from services. *[For a youth age 15 years and older]*

PARENTING: *This indicator measures the degree of caregiving capacities that the focus youth demonstrates with his/her own child (ren).* Degree to which the focus youth is willing and able to provide the child(ren) with the assistance, supervision, nurturance, protection and emotional and other support(s) necessary for adequate daily caregiving and child development.

10a. CAREGIVER SUPPORT OF THE CHILD. Degree to which: • The parents or foster caregivers with whom the focus child is currently residing are willing and able to provide the child with the assistance, supervision, nurture, protection, and support necessary for daily living. • Where necessary, specialized supports are provided in the home to meet any therapeutic care needs of the child and to assist the caregivers in meeting those needs.

10b. GROUP CAREGIVER SUPPORT OF THE CHILD. Degree to which the child's caregivers in the group home or facility are supporting the child's care, protection, education, and development adequately on a consistent daily basis.

11. FAMILY FUNCTIONING & RESOURCEFULNESS. Degree to which the parents or caregiver [with whom the child has a goal of reunification or a concurrent goal for permanency]: • Has the capacity to take charge of its issues and situation, enabling family members to live together safely and function successfully. • Takes advantage of opportunities to develop and/or expand a reliable network of social and safety supports to sustain family functioning and well-being. • Is willing, available, and able to provide the child with the protection, assistance, supervision, and support necessary for the child's growth, development, and well-being.

12. VOICE & CHOICE. Degree to which: • The child, parents, family members, and caretakers are active ongoing participants (e.g., having a significant role, voice, choice, and influence) in shaping decisions made about child and family strengths and needs, goals, supports, and services.

Practice Performance Indicators

This Shared Practice Protocol provides ten qualitative indicators for measuring core practice functions being provided with and for the child/youth and the child's parents and/or caregivers. Performance indicators look back over the past 90 days.

1. RESPONSIVENESS TO CULTURAL IDENTITY & NEED. Degree to which: • The cultural identity of the child and family has been assessed, understood, and accounted for in the service process. • The natural, cultural, or community supports appropriate for this child and family are being identified and engaged. • Necessary supports and services provided are being made culturally appropriate. *NOTE: This indicator is applied to all families.*

2. ENGAGEMENT. Degree to which those working with the child and family (youth, parents, relatives, caregiver, and others) are: • Finding family members who can provide support and permanency for the child. • Developing and maintaining a culturally competent, mutually beneficial trust-based working relationship with the child and family. • Focusing on the child's and family's strengths and needs. • Being receptive, dynamic, and willing to make adjustments in scheduling and meeting locations to accommodate family participation in the service process, including case planning.

3. TEAMWORK & COORDINATION.

TEAM FORMATION – Degree to which: • A group of motivated, qualified people – including any informal supporters a parent or youth may invite who bring skills and knowledge appropriate to the needs of the child and family – have been identified, recruited, and made commitments to participate as team members for them. • The collective team has the ability to plan, organize, and execute effective services for the child and family, given the level of complexity and cultural background involved.

TEAM FUNCTIONING – Degree to which: · Members of the team collectively participate in the teaming process on an ongoing basis. • Actions of the team reflect effective family-centered teamwork and collaborative problem solving that support meeting the child and family's near-term needs and long-term goals as revealed in present results. • Members of the team have a working relationship the child and family and with each other.

TEAM COORDINATION: Degree to which: • Adequate leadership is evident in preparing team members in advance of meetings for upcoming decisions, facilitating teamwork activities, organizing family-centered planning and service decision processes for the child and family, and following-up on commitments made by team members to ensure that contributions are made. • Effective service organization and integration efforts are evident in the assessment, planning, and delivery of interventions to the child and family.

4. ASSESSMENT & UNDERSTANDING. Degree to which those involved with the child and family understand: • Their strengths, needs, risks, preferences, and underlying issues. • The outcomes desired by the child and family from their involvement with the system. • The "big picture" situation and dynamic factors that impact the child and family sufficiently well to guide intervention. • What must change for the child to function effectively in daily settings and activities and for the family to support the child effectively. • What must change for the child/family to have better overall safety, well-being, subsistence supports, transitions and life adjustments. • The path and pace by which permanency will be achieved for a child who is not living with nor returning to the family of origin.

5a. PATHWAY TO CASE CLOSURE. To what degree: · Is there a clear, achievable case goal including concurrent and alternative plans? •Does everyone involved, including family members, know and agree on what specific steps need to be achieved in order to achieve the case goal and close the case safely? • Is the child/family making progress on these steps and informed of consequences of not meeting the necessary requirements within the required timelines? • Are team members planning for the

youth's transition from care in APPLA cases? • Are reasonable efforts being made to achieve safe case closure for all case goals?

5b. LONG-TERM GUIDING VIEW. To what degree: • Is there a guiding view for service planning that includes strategic goals for this child that will lead to his/her functioning successfully in his/her home, school, and community including the child's next major developmental or expected placement transition?

6. PLANNING. Degree to which meaningful, measurable, and achieveable life outcomes (e.g., safety, permanency, well-being, daily functioning in fulfilling life roles, transition and life adjustment, education) for the child and family are supported with well-reasoned, agreed-upon goals, intervention strategies, and actions for their attainment.

7. SUPPORTS & SERVICES. Degree to which: • Strategies, formal and informal supports, and services planned for the child, parent or caregiver, and family are available and provided on a timely and adequate basis. • The combination of supports and services fit the child and family situation so as to maximize potential results and benefits while minimizing conflicting strategies and inconveniences • Delivery of planned interventions is sufficient and effective to help the child and family make adequate progress toward attaining the life outcomes and maintaining those outcomes beyond case closure.

8. MEDICATION MANAGEMENT. Degree to which: • Any use of psychiatric/addiction control medications for this child/youth is necessary, safe, and effective. • New atypical/current generation drugs have been tried, used, and/or appropriately ruled out. •The child/youth and parents have a voice in medication decisions and management. •The child/youth is routinely screened for medication side effects and treated when side effects are detected. • The use of medication is being coordinated with other treatment modalities and with any treatment for any co-occurring conditions (e.g., seizures, diabetes, asthma, addiction, obesity).

9. MANAGING CHRONIC HEALTH CONCERNS. *[Applies to a child having a chronic health condition that requires coordination of ongoing specialized care and treatment].* Degree to which coordination of care and treatment for the child's chronic health needs is: • Supporting adequate communications among the child's health care providers, • Resolving any medication conflicts that could arise among multiple prescribers, • Sharing essential medical information between the primary care physician (PCP) and other specialists, • Providing education and support to the child and caregiver on the use of medications and home-based treatments, and • Ensuring adequate health care management of treatment for all chronic health concerns of the child.

10. TRACKING & ADJUSTMENT. Degree to which those involved with the child and family are: • Carefully tracking the child's/family's intervention delivery processes, progress being made, changing family circumstances, and attainment of functional goals and well-being outcomes for the child and family that lead to system independence and safe case closure. •Communicating (as appropriate) to identify and resolve any intervention delivery problems, overcome barriers, and replace any strategies that are not working. • Adjusting the combination and sequence of strategies being used in response to progress made, changing needs, and knowledge gained from trial-and-error experience to create a self-correcting intervention process.

APPENDIX B

NEW JERSEY QUALITATIVE REVIEW SUMMARY OF INSTRUMENT INDICATORS

(Qualitative Review Instrument, Department of Children and Families, New Jersey)

Child and Family Indicators

Safety of the Child: Is the child protected and safe from abuse, neglect, and exploitation in his/her daily settings? Is the child free from unreasonable intimidations and fears? Do parents and caregivers provide the attention, actions, and supports necessary to protect the child from known risks of harm?

Stability: Are the child's daily living and learning arrangements stable and free from disruption? To what degree is the child stable at home, at school, and in the community? Are the appropriate services being provided to achieve stability and reduce the probability of disruption?

Living Arrangement: Is the child in the most appropriate placement consistent with the child's needs for family relationships, connections, age, ability, special needs and peer group? Is this living arrangement consistent with the child's language and culture?

Family Functioning and Resourcefulness: Does the family, with whom the child is currently residing and/or with whom the goal is to reunify, have the capacity to take charge of their situation to live together safely and function successfully? Do family members take advantage of opportunities to develop and/or expand a reliable network of social and safety supports to help sustain family functioning and well-being? Is the family willing and able to provide the child with the care and nurturing, discipline, supervision, and material support necessary for daily living?

Progress toward Permanency: Is the child living with caregivers that the child, caregivers, and other stakeholders believe will remain lifelong? If not, are timely permanency efforts being implemented to ensure that the child soon will live in enduring relationships that provide a sense of family, stability, and belonging?

Physical Health of the Child: Is the child in good health and are the basic physical health needs met? Has optimum health status been maintained? If the child has a serious or chronic physical illness, is the child achieving his/her best attainable health status given the disease diagnosis and prognosis?

Emotional/Behavioral Well-Being: Is the child presenting age-appropriate emotional, development, adjustment, resiliency and protective factors?

Learning & Development: Is the child's learning appropriate for their age group? Is the child attending school regularly (age appropriate)? Are they meeting the standards for grade level promotions? Are developmental milestones met and the child progressing as he/she should? Are there any identified developmental delays with the child?

Practice/ Performance Indicators

Engagement of the Child & Family: Is the case manager and team using engagement strategies, including special accommodations with any difficult-to-reach family members, to create/ maintain family engagement and participation in the change process? (2) Are collaborative and open trust-based working relationships with the child, family, resource family being developed to support ongoing assessment, understanding, and service planning? (3) Are those providing supports relying on a mutually beneficial partnership with the child, family, and/or resource family that sustain their interest in and commitment to a change process?

Family Teamwork: TEAM FORMATION: (1) Do the appropriate formal and informal supports for this child and family form a working team that meets, talks, and plans together? (2) Does the team have the skills, family knowledge, and abilities necessary to organize effective services for this child and family, given their particular needs and cultural background? TEAM FUNCTIONING: To what degree: (1) Do members of the family team collectively function as a unified team in planning services and evaluating results? (2) Do actions of the family team reflect a coherent pattern of effective teamwork and collaborative problem solving that benefits the child and family?

Functional Assessment & Understanding: (1) Is there an understanding of the child and family's strengths, needs, risks, and underlying issues that must change for the child to live safely and permanently with the birth family or a resource family, independent of agency supervision? (2) Are the substantial strengths, needs, and risks of the child and family identified through existing/current assessments, both formal and informal, so that there is a shared understanding of the family's situation? (3) If the child is not living with the family of origin, have the strengths and needs of the current caregiver been identified?

Case Planning Process: Is the child's/family's plan individualized and relevant to the family's needs, goals? Are supports, services and interventions coherent and uniquely matched to the child's/family's situation?

Plan Implementation: Are the services and activities specified in the child and family plan 1) being implemented as planned, 2) delivered in a timely manner, and 3) at an appropriate level of intensity and length of time? Are the necessary supports, services, and resources available to the child and family to meet the needs identified in the plan?

Tracking and Adjusting: Are the child and family status, service process, and results routinely followed along and evaluated? Are services modified to respond to the changing needs of the child and family and to apply knowledge gained about service efforts and results to create a self-correcting service process?

Provision of Health Care Services: To what degree are the health care services provided commensurate with what is required for the child to achieve and maintain his/her best attainable health status?

Resource Availability: To what degree are an adequate array of supports, services, and other resources (both formal and informal) available to support implementation of the child and family planning process? Are resources available in a timely manner, at the appropriate frequency and duration? Are the services and supports provided in a setting that is conducive to the needs of the child and family? Do the child and family have a choice of the type of services and the service providers?

Family & Community Connections: When children and family members are living temporarily away from one another, to what degree are family connections maintained through appropriate visits and other means, unless compelling reasons exist for keeping them apart? Are significant others from the community able to keep-in-touch with the youth, (e.g., best friend, youth's pastor)?

Family Supports: Are the parent(s) and/or resource family being provided the training, in-home support, supervision, resources, support-development assistance, and relief necessary to provide a safe and stable living arrangement for the child that meets the child's daily care, development, and parenting needs? If the child presents special needs with more extensive care requirements, to what degree is the family provided specialized support commensurate with what is required to meet the child's needs while maintaining the stability of the home and the family commitment to the child?

Long-Term View: Is there an explicit plan for this child and family that should enable them to live safely and independent from the child welfare system? Does the plan provide direction and support for making smooth transitions across settings, providers, and levels of service?

Transitions & Life Adjustments: To what degree: (1) Is the current or next life change transition for the child and/or parent/resource caregiver being planned and implemented to assure a timely, smooth, and successful adjustment for the child/family after the change occurs? (2) If the child is returning home or school following temporary placement in foster care, treatment, or detention, then are transitional staging plans, support arrangements, and ongoing checks being made to assure a successful transition and life adjustment in daily settings following the return?

APPENDIX C

QSR INDICATOR RATING MATRIX

UNACCEPTABLE			ACCEPTABLE		
1—Adverse Status/ Performance: Status/ practice may be absent or not operative. Performance may be missing (not done). Strategies may be contraindicated	**2—Poor Status/ Performance:** Status/ practice at this level is fragmented, inconsistent, lacking necessary intensity, or off-target.	**3—Marginally Inadequate Status/ Performance:** Status/ practice at this level may be underpowered, inconsistent, or not well-matched to need.	**4—Fair Status/ Performance:** Status/ practice is minimally or temporarily sufficient to meet short-term needs or objectives.	**5—Good Ongoing Status/ Performance:** At this level, the status/ system function is working dependably for this person, under changing conditions and over time.	**6—Optimal & Enduring Status/ Performance:** At this level there is excellent, consistent, and effective status/ practice for this person in this function area.
IMPROVEMENT		REFINEMENT		MAINTENANCE	

APPENDIX D

QUALITY SERVICE REVIEW FOR MULTI-PROGRAM PARTICIPANTS

Developed for Montgomery County, MD Department of Health and Human Services by Human Systems and Outcomes Inc., revised 2012.

Status Indicator Ratings

A QSR review determines the individual's present states of well-being, functioning capacities, and supports. The QSR reviewer examines the individual's situation to discern qualitative patterns; patterns can be positive and improving for the individual served or a pattern can be less than adequate, not progressing toward increased independence.

Based on the patterns detected via observations, interviews, record reviews, and analyses, the QSR reviewer selects an appropriate level out of six possible pattern descriptions to provide a qualitative appraisal and rating of the individual's current status for each indicator. Presented below are general definitions of the rating levels and timeframes applied for individual status indicators:

Level 6 - Optimal and Enduring Status. The situation has been generally optimal [best attainable taking age and ability into account] with a consistent and enduring high quality pattern evident, without being less than good (level 5) at any point or any essential aspects. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally optimal and enduring, never dipping below level 5 at any moment. Confidence is high that long-term needs or outcomes will be or are being met in this area—perhaps reaching the level indicated for stepping down services in this status area.

Level 5 - Substantially Good and Stable Status. The situation has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect over that time period. The situation may have had brief moments of minor fluctuation, but functioning in this area has remained generally good and stable, never dipping below level 4 at any moment. This status level is consistent with eventual satisfaction of major needs or attainment of long-term outcomes in the area.

Level 4 - Minimally Adequate to Fair Status. The situation has been at least minimally adequate at all times over the past 30 days, without being inadequate at any point or any essential aspect over that time. The situation may be dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed pattern may not endure or may have been less than minimally acceptable in the recent past, but not within the past 30 days.

Level 3 - Marginally Inadequate Status. The situation has been somewhat limited or inconsistent over the past 30 days, being inadequate at some moments in time or in some essential aspect(s) over this time period. The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have endured or may have been less than minimally acceptable in the recent past and somewhat inadequate.

Level 2 - Substantially Poor Status. The situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s). The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured or may have been inadequate and unacceptable in the recent past and substantially inadequate.

Level 1- Adverse or Poor and Worsening Status. The situation has been substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. The observed pattern may have endured or may have recently become unacceptable, substantially inadequate, and worsening.

Service System Performance Indicator Ratings

Based on discernment of patterns obtained via observations, interviews, record reviews and analyses, the QSR reviewer selects an appropriate level out of six possible pattern descriptions to provide a qualitative appraisal and rating of the service system's current performance for each indicator. A rating reflects the degree of performance adequacy that the service system provides for each core practice function at the time and place of review. The same general logic is applied to system performance rating levels as is used with the status indicators. The general interpretations for performance indicator ratings are defined as follows:

Level 6 - Optimal and Enduring Performance. The service system practice/system performance situation has been generally optimal [best attainable given adequate resources] with a consistent and enduring pattern evident, without ever being less than good (level 5) at any point or in any essential aspect. The practice situation may have had brief moments of minor fluctuation, but performance in this area has remained generally optimal and stable. This excellent level of performance may be considered "best practice" for the system function, practice, or attribute being measured in the indicator and worthy of sharing with others.

Level 5 - Good and Stable Performance. The service system practice/system performance situation has been substantially and consistently good with indications of stability evident, without being less than fair (level 4) at any moment or in any essential aspect. The situation may have had some moments of minor fluctuation, but performance in this area has remained generally good and stable. This level of performance may be considered "good practice or performance" that is noteworthy for affirmation and positive reinforcement.

Level 4 - Minimally Adequate to Fair Performance. The service system practice/system performance situation has been at least

minimally adequate at all times over the past 30 days, without being inadequate (level 3 or lower) at any moment or in any essential aspect over that time period. The performance situation may be somewhat dynamic with the possibility of fluctuation or need for adjustment within the near term. The observed performance pattern may not endure long term or may have been less than minimally acceptable in the recent past, but not within the past 30 days. This level of performance may be regarded as the lowest range of the acceptable performance spectrum that would have a reasonable prospect of helping achieve desired outcomes given that this performance level continues or improves. Some refinement efforts are indicated at this level of performance at this time.

Level 3 – Marginally Inadequate Performance. The service system practice/system performance situation has been somewhat limited or inconsistent, being inadequate at some moments in time or in some essential aspect(s) over this time period_ The situation may be dynamic with a probability of fluctuation or need for adjustment at the present time. The observed pattern may have been less than minimally acceptable (level 3 or lower) in the recent past and somewhat inadequate. This level of performance may be regarded as falling below the range of acceptable performance and would not have a reasonable prospect of helping achieve desired outcomes. Substantial refinement efforts are indicated at this time.

Level 2 – Substantially Poor Performance. The service system practice/system performance situation has been substantially limited or inconsistent, being inadequate at some or many moments in time or in some essential aspect(s) recently. The situation may be dynamic with a probability of fluctuation or need for improvement at the present time. The observed pattern may have endured for a while or may have become inadequate and unacceptable in the recent past and substantially inadequate. This level of inadequate performance warrants prompt attention and improvement.

Level 1 – Absent, Adverse, or Poor Worsening Performance. The service system practice/system performance situation has been missing, inappropriately performed, and/or substantially inadequate and potentially harmful, with indications that the situation may be worsening at the time of review. The situation may be dynamic with a high probability of fluctuation or a great need for immediate improvement at the present time. This level of absent or adverse performance warrants immediate action or intervention to address the gravity of the situation.

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