Utah Child and Family Services Review Round 3
Program Improvement Plan

Goals, Strategies, and Key Activities
for PIP Implementation

October 2019

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Part One: Goals, Strategies/Interventions, and Key Activities

Utah Division of Child and Family Services (DCFS) is a state administered child welfare agency under the Utah Department of Human Services (DHS). DCFS has five regions with 28 local offices and a state office located in Salt Lake City. In July 2018, a traditional Child and Family Services Review was conducted in three sites: Salt Lake County, Cache County, and Iron County. Utah received the final Child and Family Services Review (CFSR) report on January 25, 2019.

Utah is committed to improving practice and systems to keep children safe and strengthen families. This is demonstrated by historical quality improvement efforts and by new initiatives, both within the child welfare agency and in partnership with the broader child welfare community and stakeholders, including children and families that we serve.

Utah has engaged in continuous quality improvement efforts since the mid 1990's when it entered into a settlement agreement as a result of the David C. lawsuit. Utah successfully exited the lawsuit in 2010 and has kept intact the practices that were established as a result. A key milestone was development, training, and implementation of the Utah Practice Model. Also implemented was the Qualitative Case Review (QCR), which measures child status and adherence to the Practice Model. The QCR tool was developed by Human Systems and Outcomes, Inc. and is a qualitative review method based on interviews with key people associated with a case that is selected randomly for review. Reviews are conducted in each region every year, with approximately 150 cases state-wide being reviewed annually. The QCR has been in place for 20 years and is required by Utah law. Because of the wealth of data that has been accumulated over the years and the requirement to conduct the QCR annually, Utah will incorporate the CFSR Program Improvement Plan (PIP) measurement review process into the QCR process.

Utah DCFS also has a history of working extensively with stakeholders. For example, DCFS has a great working relationship with the Utah Court Improvement Project (CIP) and asked this committee to explore and coordinate issues regarding permanency and other court challenges related to the CFSR findings. Utah Quality Improvement Committees (QIC), developed during the lawsuit, are also important partners, with local QICs in each region and the Child Welfare Improvement Committee (CWIC) at the state level. Members include partner agencies, community members, stakeholders, and DCFS administration. CWIC has been involved with the development of the PIP and will also be involved with implementation. In addition, stakeholders were involved in the problem exploration phase for specific CFSR findings. Stakeholder involvement was in person, through focus groups, or through surveys. Stakeholders included the Court Improvement Project (CIP) members, legal partners working with the child welfare courts (judges, guardian ad Litems, AAG, parental defense lawyers); the Youth Council, which includes current and former foster youth; foster parent groups; and placement provider representatives, parents, caseworkers, and other DCFS staff. The involvement of key stakeholders will be ongoing as DCFS continues to develop tools and strategies.

New initiatives also support continuous quality improvement and serve as a backdrop for PIP activities. Components of these initiatives will be key to cross-cutting strategies, which are expected to significantly improve the quality and consistency of practice and should support improvement for multiple CFSR items. Initiatives currently in development include state-initiated **Operational Excellence;** the Family First Prevention Services Act **(FFPSA)** implementation, particularly prevention services and fatality review components; and **DHS Office of Quality and Design (OQD)** development and implementation. These initiatives are further described below.

Development of the PIP

Efforts to understand the CFSR results and develop meaningful strategies for the PIP began soon after the CFSR was completed in 2018. Gathering and analyzing additional data was the starting point. Data collection actually began prior to the CFSR onsite review, when Utah started working with the Capacity Building Center for the States (CBCS) data center to begin analyzing data on abuse in foster care, which was an area of concern for Utah. After entering into a data agreement, raw data for five years was sent to the CBCS data team. In October 2018 data on placement stability, another area of concern, was sent to the CBCS data team for analysis. In addition, the University of Utah School of Social Work, Social Research Institute (SRI), analyzed data on safety during trial home placements (THP), in response to findings from the onsite review about insufficient assessment of ongoing safety and risk (item 3).

Workgroups were assigned to specifically address certain CFSR items and outcome. DCFS administration identified initiatives and formed workgroups during the time between the onsite review and the release of the Utah CFSR Final Report. Workgroups encompassing Safety, Improved Permanency Outcomes, and Wellbeing 1 were formed. CFSR Safety 1 and 2 Outcomes were included in the Safety Workgroup. The Permanency workgroups consisted of two groups, with one group tackling placement stability and the other group (CIP) working on court related issues impacting the achievement of permanency.

As workgroups began and feedback was provided, adjustments were made. For example, it was decided that Well-Being I issues, in particular service provisions for and engagement of parents, were closely related to the need to better support DCFS workforce and increase capacity so that caseworkers have the time for quality engagement of families. It became apparent that the DCFS Operational Excellence initiative was optimal for addressing this need and would also serve as a cross-cutting strategy to strengthen quality and consistency of practice, as well as provide a supportive structure for quality supervision.

Operational Excellence is a large-scale, ambitious system effort focused on strategically evaluating and allocating resources to ensure that they are optimally aligned in the service of enhanced child and family outcomes. The emphasis is on improving the flow of work and quality of casework, even in a climate that offers no additional financial resources. DCFS is encouraged by successful Operational Excellence initiatives in other DHS divisions (Juvenile Justice System and the Utah State Hospital) and expects that the implementation of its Operational

Excellence initiative, which targets work processes and workflow, will significantly improve consistency of practice, in particular, the ability of staff to focus on critical activities, such as addressing the safety of children and engaging parents. Leaders involved in designing the tools for this initiative have also participated in various PIP workgroups and will incorporate the identified PIP strategies into Operational Excellence processes. This allows the agency to introduce the changes to the workforce as one meaningful initiative, rather than as separate projects, and will ensure that the changes are well coordinated. Operational Excellence is further described below and will address practice issues identified under Wellbeing Outcome 1 (Items 12-15), strengthen the assessment of safety during home visits at critical junctures, and any items that showed inconsistencies of practice (Permanency Outcome 2: items 7-10; Well-being Outcomes 2 and 3: items 16, 17, and 18).

Utah DCFS used a slightly different approach in planning how to address **Service Array**, the one CFSR Systemic Factor where improvement was needed. As the agency began a root cause analysis to better understand how to address service array shortcomings, it became evident that a major initiative already underway within the Department of Human Services (DHS) was focusing on availability and accessibility of department-wide contracts, allowing contracted services to be available to all clients of the department across any division. This department-wide effort meant that all services contracted by any division or office in DHS could be made available to families served by DCFS, whether the children were receiving services in their home or in foster care. Current and prospective initiatives planned by OQD (described in the Systemic Factors section) are expected to address service array needs identified in the Statewide Assessment and the CFSR.

Additionally, DHS is actively working to implement provisions of the **Family First Prevention Services Act (FFPSA)**, which are expected to increase service array capacity. The prevention services provisions will provide evidence-based mental health and substance use disorder prevention and treatment services and in-home parent skills-based programs to families to prevent the entry or reentry of children into foster care. DCFS also anticipates adding kinship navigator services under Title IV-E to help kin caregivers better access needed services and care for children placed with them. Also related to FFPSA, a renewed focus on child fatalities and the need to tackle the process by which the division learns from the review of each fatality has led to **implementation of specific tasks to preserve child safety and prevent fatalities** due to abuse, neglect, accidents, or suicide. DCFS is currently partnering with local universities on a number of research projects around child safety, in particular child fatalities and near fatalities. A study is analyzing the CARA components of the Child Abuse Prevention and Treatment Act, so DCFS can determine how to strengthen supports to children born to mothers using substances. Work is underway to enhance collaborations with agencies and organizations who provide programs specifically designed to serve this population, such as Safe and Healthy Families, Department of Health, United Way and Division of Substance Abuse and Mental Health.

An analysis of child fatalities and near fatalities conducted in the past year brought renewed attention to the most extreme consequence that can occur when child safety is not attained, with children under age one being most at risk. The data showed that children under age five are at high risk of maltreatment, especially children age one year or younger who accounted for 69% of fatalities in SFY18. This prompted DCFS to challenge a “one size fits all” approach to child protective services responses and **design and implement a differing CPS response based on child vulnerability**. This will be one of the main focuses of Phase II of Operational Excellence, which will launch at the end of October 2019. It will start with a revision of how Centralized Intake receives and records child maltreatment allegations and determines the

type and level of response. Preliminary research to explore how other states respond to child abuse allegations for different age groups is underway.

Leadership Academy: Utah DCFS developed a Leadership Academy in early 2018 to prepare agency leaders and supervisors to engage in transformational leadership. The material used originally in the development of the Utah Leadership Academy curriculum came from Indiana University School of Social Work, and was based on training material from the National Child Welfare Workforce Institute (NCWWI). The original material was revised internally by Utah's training team to meet the needs of Utah's child welfare leadership and workforce. Four modules were developed along with trainer manuals and participant manuals for each module. The primary purpose of the Leadership Academy is to reinforce the supervisory skills needed to ensure that the delivery of child welfare practice produces the desired outcomes of safety, permanency, and well-being for children and families consistently and across all cases.

The Leadership Academy was initiated in September 2018 for regional leadership, which included regional directors, associate directors, and child welfare administrators participating. The reception of training by region leadership was very positive. Planned training specifically for region supervisors was delayed due to competing priorities under Operational Excellence and the Family First Prevention Services Act. Due to needs identified in the CFSR, in particular issues identified when exploring root causes for Permanency 2, and Well-being 1-3, the Leadership Academy will be activated as a cross-cutting strategy, focusing on strengthening supervisors' ability to understand and track the assessment of family needs, engagement of family members including kin, and provision of the right service on a consistent basis.

Additional technical changes: Besides recognizing the need for large-scale cross-cutting adaptive changes to Utah's child welfare system, the CFSR also brought to light the need to make some technical changes. Utah's policy for conducting annual dental exams of children in foster care, for example, does not align with the national pediatric dental recommendations. Utah will be making a technical change to the requirements for dental examinations to align the requirements with the pediatric dental recommendations of **a dental exam every 6 months**. As described in the Statewide Assessment, Utah has a wonderful arrangement with the Health Department to access the services of qualified nurses assigned to every foster child. They are located in the DCFS offices and work along the DCFS caseworker to track the children's health needs and make sure they receive the services they need. Therefore, the adjustment to the dental practice guideline should be the only change necessary to address missed health assessments and services for Item 17. Additional technical changes are captured in individual sections of the PIP.

Cross-Cutting Strategy 1: Operational Excellence Initiative

In March 2019, Utah convened leaders within the agency and external consultants specializing in workflow analysis to study how lost productivity negatively impacts families along the continuum of child welfare. Over several days, the group immersed itself in reports, data analysis, input from workgroups, and research to understand the root cause of lost productivity and the effect it has on family outcomes. They identified key areas in DCFS that needed to be addressed and started working on a **value improvement plan**.

Underlying Issues

Child welfare is a challenging and complex system with requirements and policy and procedures that do not always align with Utah's goal of all children safe from abuse and neglect. Utah currently experiences a cycle in which it loses expertise and capacity needed to support its workforce and serve families. The challenging and complex system is demonstrated in Utah's front line high turnover rates (FY 2018, Utah experienced 31% turnover of frontline caseworker positions, up from 19.9% in 2012 and 23.2% in FY 2014). This vicious cycle results in DCFS defaulting to compliance driven work that can negatively impact the quality of the work with families. As such, staff do not consistently engage, team, assess, plan, and intervene to the level necessary in order to facilitate transformational change. The outcome potentially compromises child safety, permanency, and family outcomes. This leads to more requirements, policy, training, procedures, and measures, which overburden the workforce with constantly increasing, changing, and competing requirements and expectations. This vicious cycle, in combination with unpredictable mandates, interruptions, and crises, leads to low morale and high turnover. The cycle then repeats. To break this vicious cycle, the agency realized the need to focus on improving work processes and workflow, reallocating resources to key priorities. It is expected that this focus will significantly improve consistency of practice, in particular the ability of staff to address critical activities aimed at child safety and improved family outcomes.

Background

Knowledge gained during the recent implementation of Strengthening CPS - an initiative aimed at improving work processes in CPS cases based on the Theory of Constraints - was used as the basis of discussion. In that initiative, a number of workflow constraints and inefficiencies had been identified in CPS cases and, as a result, a work management process aimed at improving casework processes and outcomes for families was introduced. The pilot implementation of Strengthening CPS included regular feedback sessions with region administration, CPS supervisors, and the implementation team. The sessions were designed to learn from the field and were held every 10 days for over one year, creating an ongoing state of continuous quality improvement. During the sessions, strategies were refined and processes revised. This 10-day cycle of process improvement sessions repeated until the successful implementation of Strengthening CPS was completed. Data indicates this initiative resulted in improved safety outcomes for children through timeliness of face-to-face contacts and reduced length of case duration (see graphs below).

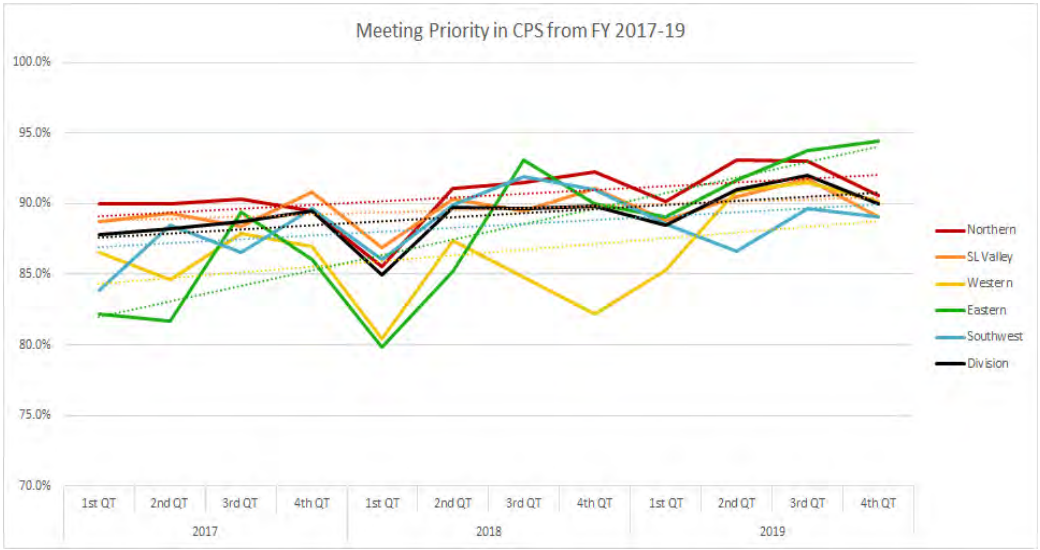
Strengthening CPS Implementation Data

The table below shows the reduction in the duration of CPS cases in the Ogden pilot site from 32.5 days prior to starting the initiative to 26.3 days after implementation, while the rest of the state actually increased. The data in the graph on the right shows an increase in the percent of cases meeting the requirement of timely face-to-face contact with the child victim in CPS cases - which is a child safety indicator - in every region since 2017. It went from 87.8% statewide at the beginning of the fiscal year 2017 to 92% earlier this year. The Strengthening CPS initiative was implemented in each region between 2017 and 2019. While other factors can influence the timeliness of this activity, Utah is still encouraged to see notable progress during this period.

CPS Case Duration

Area	Base Period	Pilot Period
Ogden	32.5 (18.4)	26.3 (16.4)
Northern	34.1 (20.6)	31.6 (20.1)
State	34.8 (25)	36.3 (27.2)

human services



In addition, the project implementation team has noted better use and accuracy of Structured Decision Making (SDM) assessments and Safety Plans, improvements in the design and use of the tools that were introduced through this project, and standardized batching procedures (case assignment/distribution process that creates a more predictable schedule for CPS caseworkers and allows for schedule planning and crisis management). The team has also noted improvements in caseworker's rapid relationship building skills, which are critical for successful CPS work with families. Furthermore, the process has strengthened coaching concepts supervisors use for training caseworkers.

Well-Being 1 Root Causes

Work done around analyzing the root causes for the low results in Well-Being 1 items (45% overall) further strengthened the resolve to address capacity and workflow issues, as well as quality supervision. After thoroughly reviewing the CFSR results on Wellbeing 1, in particular on Items 12 and 15 regarding the causes for insufficient engagement of parents, assessment of their strengths and needs and provision of services, as well as reviewing findings from QCR's on Assessment and Intervention Adequacy, Utah decided to convene a large group of stakeholders, including DCFS administrators, caseworkers, parents who had received services, foster parents, members of the audit team, community partners, and legal partners to identify root causes and barriers to achieving critical engagement of parents and families. This meeting took place on February 7, 2019, right after the presentation of the final CFSR Report and was well attended, including by Region VIII staff. The meeting reviewed the previously conducted problem exploration findings, including data analysis from the CFSR, QCR, CPR and other sources to better understand the root causes for issues identified in the review of Well-Being 1 items. The group then used a Liberating Structure tool for brainstorming to generate possible root causes.

Assessing Needs and Providing Services to Parents. What we know:

- CFSR score on Item 12-B was **56%**.
    - Same across all 3 sites
    - Slightly better on foster care cases than in-home cases
    - Slightly better for mothers than fathers
- DCFS practice guidelines require:
    - Monthly contacts with both parents
    - Involving parents in team meetings to develop plans
    - Involving them in the UFACET (family strengths and needs assessment)
- Overall QCR scores on Assessment and Intervention Adequacy are around 80-83%, scores for mothers and fathers mirror more the CFSR scores (60ies-70ies). Fathers usually fared worse than mothers.
- Summary of findings: Issues identified in reviews include:
    - Overlooking the non-custodial parent/secondary caregiver
    - Parent assessed but assessment was inadequate
    - Service not provided or insufficient/not adequate
    - Lack of monitoring and follow-up to check that parent is receiving/ accessing service
    - Parent's needs were not assessed when child came into care for dependency or their own behavior

One of the main barriers identified by staff was the **lack of time** available to spend quality time with parents and assess their needs and monitor their services, with **inefficiencies in the workflow** taking valuable time away; staff identified **a need for more support,** clinical and non-clinical, to better understand the families' needs and address the barriers to effective service provision. Requirements for parent engagement and involvement through the Family Teaming process and in individual visits, as well as a minimum number of monthly visits is already part of DCFS policies and its practice model and is trained right from the beginning of employment. This is recognized as a strength and staff seem to understand the value of it, but the **capacity and support** for staff to do this well was clearly identified as a problem. Finding solutions to create capacity, improve productivity, and add supports for caseworkers to better engage parents was recognized as the main need.

Utah has chosen to address the assessment and provision of services, Item 12, as well as other CFSR outcomes, by using an **Operational Excellence initiative**. As explained earlier, the main components of this large-scale initiative will provide the structure for supervisors to assess how well the parents' needs have been assessed and met and to provide support to caseworkers in overcoming any barriers they encounter when doing this. The plan to implement a statewide Leadership Academy next year will further strengthen the role of the supervisor in providing that support to caseworkers.

Well-Being 2 and 3 Root Causes:

Item 16 - *Educational Needs of the Child* was an Area Needing Improvement with 82% of the 34 applicable cases being rated as a Strength, or six cases reviewed receiving an ANI. The analysis of the ANI's showed that the main concern, i.e. lack of tracking of child's educational needs and services, could have been bolstered by better supervision of the caseworker through mentoring and coaching.

On Item 17- *Physical Health of the Child*, 11 of the 12 applicable cases that didn't receive a Strength rating were lacking the 6-month dental exam because Utah requires only annual dental exams for children in foster care. As mentioned in the introduction, Utah will be making a technical change to the requirements for dental examinations to align the requirements with the pediatric dental recommendations of a dental exam every 6 months. On Item 18 - *Mental Health of the Child*, the reviewers noted that concern was less an issue of identifying and assessing the child's mental health needs but more with tracking that the treatment was provided and producing the desired outcome.

As in Well-Being Outcome 1, Utah will be addressing these outcomes through the Operational Excellence cross-cutting strategy which will strengthen practice oriented supervision and allow supervisors to better mentor/coach/ support caseworkers to address these critical needs of children. The Leadership Academy will further reinforce the role of supervisors to actively monitor and support caseworkers in addressing these child needs.

Conclusion

The confirmation needed to embark on this ambitious Operational Excellence initiative designed to address larger system changes was provided by:

- Internal lessons learned from the implementation of **Strengthening CPS initiative**
- **Well-Being 1 root cause analysis**, which identified the need to create capacity, improve productivity, and add supports for caseworkers to better engage parents as the main problem to solve.
- **Well-Being 2 and 3 root cause analysis**, which identified a need to better track educational and health needs and the services to address them.
- Research done on system reform projects based on the **Theory of Constraints in other industries**
- Experience gained from similar Operational Excellence initiatives implemented in **other DHS divisions** (Juvenile Justice System, the Utah State Hospital, and System of Care)

Theory of Change Basis for Developing Operational Excellence

Utah DCFS will generate expertise and capacity to support workers and serve families. This will include eliminating tasks, responsibilities, and initiatives that take away from critical activities, as well as aligning our system and resources to ensure all children are safe from abuse and neglect.

- so that Utah can move from a reactive approach to a proactive one and create space for thoughtful and deliberate ongoing improvement across the system
- so that workers, supervisors, and administrators are able to effectively prioritize requirements and expectations
- so that the workforce feels supported in the work throughout the system and experiences reduced turnover
- so that caseworkers are able to spend quality time with families to better assess their strengths and needs and provide timely and appropriate services to achieve safety for children
- so that the workforce is able to holistically engage, team, assess, plan, and intervene in order to facilitate transformational change throughout the system
- so that child safety and outcomes for families are strengthened.

Expected outcomes: Utah DCFS leaders set ambitious targets and believe there is hidden capacity in operations. It is anticipated that Operational Excellence's expected outcomes will improve workflow processes and will improve the management of critical tasks, such as family engagement and assessment. Critical tasks to monitor and address safety concerns and stabilize families will be "front-loaded" and, as such, are expected to prevent unnecessary removals. It is also anticipated that DCFS will improve the quality of operations by focusing on the people who do the work (frontline staff). Frontline staff carry out the activities that help to achieve agency goals. Reduced recidivism, increased safety, shortened case length, and increased kinship involvement and kin placements are additional anticipated long-term outcomes.

Activities and Steps

Utah DCFS will improve how work flows through the child welfare system. Improving flow generates more system time and capacity to focus on and deliver quality content (such as evidence based practice). Focusing on flow ahead of content creates the needed capacity to improve the quality of content over time. Improving workflow will result in cases moving more efficiently and effectively through the system to case closure. As a general rule, the longer a case stays in the system, the opportunity for positive results typically decreases and/or the work it takes to achieve them increases.

This process will incorporate input from frontline staff, community partners, and support from Utah's Governor's Office of Management and Budget. Utah DCFS will also collaborate with its sister agencies under the Department of Human Services and the Department of Health who are engaging in similar system improvements.

Utah DCFS will create a structure to support supervisors in quality supervision. Operational Excellence is primarily aimed at strengthening the ability of supervisors to effectively move casework forward to achieve the goals identified by the family served.

To accomplish this objective, the agency will develop and implement a Work-in-Process (WIP) structure based on the same concepts used in Strengthening CPS and aligned with the Theory of Constraints and Operational Excellence principles, using tools modeled in other industries. The process will be used for ongoing case work (foster care and in-home).

To support the WIP structure, supervisors are provided the tools needed for their success (see table below). They also receive the necessary training on how to properly use the tools, which enables them to more effectively manage casework and the progression of cases through the system and toward the achievement of case goals. Supervisors are trained to their unique role using the teach/show/do model.

For example, supervisors are provided a WIP board tool (called MAP Boards - Managing Active Progress - see example below). These boards contain columns for essential tasks that need to be completed on each case; they allow supervisors and their teams to visually track the progression of case towards closure and make sure that essential tasks are completed) and are trained on how to use their MAP board. Additionally, supervisors are trained on how to successfully use daily stand-up morning meetings with their staff. In these meetings, critical

case practice activities are determined for the day, using the MAP board, and any need for additional caseworker support is identified and scheduled.

Supportive coaching is provided to supervisors by experts who attend a number of standup meetings in-person or remotely and who have access to the meetings' MAP boards. This coaching support is provided for several weeks to ensure fidelity of the process.

Through the MAP process, the team builds cohesion and improves team support. Preliminary feedback from caseworkers is that, because of the daily MAP meetings, they now feel like their supervisors know what is going on with their workdays and with their cases. Especially newer caseworkers and supervisors appreciate this new process. DCFS is encouraged that these early indicators show an improvement in the quality of supervision. Using a MAP board in a daily stand-up meetings, coupled with strategic supervisor staffings ensures case movement and a focus on critical activities for the frontline.

Eventually, a similar process will be developed for all program types including Drug Court, specialized teams and administration.

Example of a MAP Board, developed for Phase One of Operational Excellence:

CASE INFORMATION				INITIAL ENGAGEMENT & PLANNING				IMPLEMENT SERVICES, TRACK, & ADAPT									FAMILY TARGET COMPLETION DATE	TRANSITIONS	DAILY TASKS	TIME	NOTES
#	SAFE CASE NAME	CASE START DATE (CSD)	CASE TYPE	INITIAL ENGAGEMENT	ENGAGE & ASSESS FAMILY & YOUTH	KINSHIP SEARCH & ENGAGEMENT		CONCRETE SUPPORTS & SOCIAL CONNECTIONS	SERVICES INITIATED?	VISITS/CONTACT		FAMILY/YOUTH-DRIVEN TEAMING	UFACET & PLAN UPDATES		FAMILY/YOUTH-DRIVEN PARTNERING WITH COURT		LONG TERM VIEW				
For clarifying information on this section, click here				Worker Transition Meeting Initial Engagement With Family CFTM	Complete with the family: UFACET, SDM Safety & Risk, Child & Family Plan ✓ Review ✓ Agenda ✓ Sign ✓ Submit	At risk of Removal / Placement Disruption	Ongoing search for kinship	Identify needs	Family/Youth goal date for receiving referral(s) to services	Family/Youth goal date to initiate service(s)	Risk level	# of visits (based on risk level or case type)	Date of next visit needed	Date of next CFTM	Update UFACET	Update Child & Family Plan & Target Completion Date	Next court date	Court report due date	Family/Youth-driven timeframe	In-Home to Case Closure SCF to In-Home SCF to Adoption Aging Out Worker to Worker			
1	Montana, B	3/8/12	SCF					TC-DSPD, MH, WWK			SCF	1			6/29/18	4/22/19			1/15/20				Waiting for DSPD Waiver
2	Alabama, C	6/13/19	PSC								Moderate	2											
3	Georgia, J	6/7/18	PSS		✓			MO/SFA-PT FA-			Very High	3											Transition to close case
4	Colorado, H	4/19/19	PSS		✓	✓		MO-~~MH~~, Housing, Employment, SUD TC-~~MH~~			High	4			2/1/19				10/18/19				
5	Alaska, L	10/3/18	SCF		✓	✓		MO- ~~Employment~~;TC-MH tx			SCF	3									Motion for trial home placement, felony check	3	Trial home placement
6	Alaska, A	10/3/18	SCF		✓	✓		TC- Grant for dresser			SCF	2											Trial home placement
7	Alaska, E	10/3/18	SCF		✓	✓		MO- ~~Employment~~; TC-MH tx			SCF	2											Trial home placement
8	Arizona, K	10/3/18	SCF		✓	✓		MO/FA- Coparent plan			SCF	3											Trial home placement
9	Maine, K	11/7/18	PSS		✓	✓		MO/FA- Aftercare sup			High	2											
10	Ohio, Z	1/9/18	SCF		✓	✓	✓	MGM- ~~Housing~~; TC-MH tx, family tx at step down	9/30/19		SCF	4				4/18/19			1/1/20				Transition to TAL
11	California, L	6/3/19	PSS			✓		MGM-visit plan; TC-MH TX			Low	2		10/2/19									Case closure in at next he
12	Louisiana, G	5/23/19	SCF		✓	✓		MO- ~~SA~~, DVA; TC-MH tx			SCF	4		10/2/19					10/31/19		Dv assessment follow up, schedule cftm	1	
13	Louisiana, C	5/28/19	SCF			✓		MO- ~~SA~~, DVA			SCF	4									Y22		Trial home placement
14	Louisiana, A	5/28/19	SCF			✓		MO- ~~SA~~, DVA			SCF	4									Trial home placement		Trial home placement
15	Nebraska, A	6/26/18	SCF		✓		✓	TC- Immigration			SCF	3			4/23/19	5/8/19							ICPC in Florida
16	Nebraska, C	6/26/18	SCF		✓		✓	ALI- ~~TANF~~; TC- Medicaid			SCF	3			4/23/19	5/8/19							ICPC in Florida
17	Maryland, G	9/14/18	SCF		✓	✓		MO- SA tx, MHA			SCF	2			5/15/19	1/22/19			11/15/19				Permanency hearing in J
18	Maryland, M	9/14/18	SCF		✓	✓		FA- Housing, peer par			SCF	2			5/15/19	1/22/19			11/15/19				Permanency hearing in J
19	Texas, T	5/7/19	SCF			✓		MO- SA, Housing			SCF	4				5/7/19			12/30/19				
20	Michigan, A	3/1/18	SCF		✓	✓		N/A			SCF	1			5/13/19	3/13/19							Case closed
21	Kentucky, D	5/22/19	PSS			✓					Moderate	0											Paper review, asked to c

** All names used in this example are fictive names.*

Goal 1: DCFS has the expertise and capacity to support caseworkers and serve families to achieve child safety and improve family outcomes (P2, WB1, WB2, WB3)

Strategy 1: Standardize daily operations and improve the flow of work throughout the system with a focus on critical decisions and activities (through Operational Excellence initiative).

	Key Activity	Project Lead	Projected Completion Date
1.1.1	Generate time (capacity) for transformational interventions by streamlining work processes. ➔ Create and implement a Work-in-Process (WIP) structure and tools to track critical caseworker tasks, assignments, and projects being worked on simultaneously for ongoing cases (foster care and in-home cases). The main components of this process consist of MAP Boards (Managing Active Progress) and quick daily standup meetings for supervisors and caseworkers to review and prioritize the tasks needing completion that day and any issues requiring further attention. This process helps reduce multi-tasking and increases synchronization of services so that time frames can be driven by family needs. It helps workers and supervisors identify which cases may need additional support to achieve safety at any given time. Several points of the MAP boards prompt workers to seek families' input on their time frames and increases their decision-making power. For example, the Family Target Completion Date needs to be discussed with the family early in the case and reviewed at team meetings to ensure the case is progressing at a pace that makes sense to the family (within the context of non-negotiables). Implementation consists of: a. Developing a MAP Board for ongoing cases with the participation of front line supervisors - see example board provided above (completed in May 2019). b. Kick-off information sessions in every office to prepare workforce for the upcoming process change, help them understand the reasons behind the change, and answer any questions (completed by the DCFS Director in May and June 2019).	Project Administrator and Project Coordinator	May 2020 (initial implementation through Nov. 2019, CQI to monitor implementation plus project adjustments anticipate by Nov 2020, then ongoing CQI)

	Key Activity	Project Lead	Projected Completion Date
1.1.1	c. In-person or online training of supervisors in every office, followed by trainings/modeling for each team - supervisor and their staff (completed June through September 2019). d. In-person or online supervisor coaching of the daily standup meetings and MAP boards by designated "MAP coaches" during the first 6 weeks (completing July through November 2019). For the purpose of CQI, feedback sessions will be held to further refine the process and tools. CQI activities include: - Surveys held at 3, 6, 9 months post-implementation - Meetings with region administrators and supervisors to obtain feedback - Random spot checks to ensure fidelity to process - Quarterly progress reviews in state leadership team - Initial MAP Retrospective Review: Nov 2020; will be when we have a full year of data on MAP (including the 4 worker & supervisor surveys at various points throughout the year and the data pieces (see below) Ongoing tracking of data, including: - Average time to case closure: 2 year baseline with rolling quarter by region and state - QCR indicators: LTV, Tracking & Adapting, Teaming, Assessment - CFTM within 15 days - UFACET & Plan within 45 - # of children placed with kin - Home visits & contact with parent child		
1.1.2	Develop Full-Kits of the DCFS system and community resources for the family and kin to increase their ability to fully participate in their own cases. Full-kits are developed by those receiving the information, not those giving the information. This is an important concept and determines the extent of the full-kit. The term, Full Kit, implies having all the correct information, data, tools, requirements, approvals, and/or documentation needed to start a project or to complete a task. Full Kits can include: (1) Information for families on what to expect from the child welfare system and	CQI Administrator	November 2019

	Key Activity	Project Lead	Projected Completion Date
1.1.2	how the process works; (2) physical items when applicable (tools/resources), and (3) an operationalized process that increases their voice throughout the life of the case. Full kits can help avoid bad multitasking, process wait times, rework, and delays caused by hand-offs between functions. Primarily, full kits empower clients by giving them the information and tools they need to be informed participants in their own cases. For this first phase of full-kit development families/parents/kin involved in the system were asked what information would be helpful at the identified critical junctures. With their input new brochures were produced and delivered to regions staff with instructions, as part of this first phase, (Summer 2019). The pamphlets include: ➔ *"What to Expect if an Allegation of Abuse or Neglect is Made" (for foster parents)* ➔ *"HomeWorks: A Family Guide to In-Home Services"* ➔ *"A Guide for when your Child is placed in Protective Custody"* ➔ *"A Guide to Kinship Care"* ➔ *"Adopting Children from State Custody"* ➔ An additional pamphlet/tool is being developed for youth who come into foster care and are old enough to understand the information (expected completion by January 2020). In addition, a set of safety items has been assembled for CPS caseworkers to hand out to families to enhance their ability to provide safe homes. They include baby safe sleeping boxes (in an effort to reduce the incidents of SIDS), medication dissolve kits to dispose of unused medicines, medication lock boxes and gun locks.		
1.1.3	Assess projects, meetings, committee, and work processes at state and region levels. Triage items that take time away from more critical work to align focus to agency goals.	Project Administrator and Project Coordinator	November 2019
1.1.4	Streamline and/or eliminate individual trainings - initial and ongoing trainings - to reduce duplicative efforts in order to free up worker time to work with families.	Training Director	January 2020

	Key Activity	Project Lead	Projected Completion Date
1.1.5	Streamline and/or eliminate individual finance procedures to ensure that resources (worker and supervisor time) are used efficiently. This includes eliminating duplicative efforts that are essentially a rubber stamp of approval.	Finance Director	January 2020

Strategy 2: Implement changes to streamline the system, improving the experience of families engaged in services and increasing responsiveness to families through ease of access to the right services at the right time.

	Key Activity	Project Lead	Projected Completion Date
1.2.1	Plan and re-design DCFS system to be more responsive to family needs and produce the best outcomes, be responsive to the assessed safety and risk level, focus on upfront practices, and create an organizational structure to support this response. A two-day kickoff session for the second phase of Operational Excellence occurred at the end of October 2019 and involved administrators from the state office and all regions, as well as consultants in Theory of Constraints. This was the starting point to identify and develop the main strategies needed for phase II. The following goals were formulated: ➔ Re-design a frontend system with improved focus on safety and risk. ➔ Improve process for responding to safety and risk throughout the system (critical decision points and case transfers). The process will focus on safety decisions, safety interventions, and prevention of foster care. The workgroup identified the need to initially focus on frontend of services including intake, disposition, CPS response, decision making/triage, kinship involvement, and the initial phase (first 30-60 days) of an ongoing case.	Project Administrator and Project Coordinator	October 2020 (Start of intervention design Jan. 2020, phased implementation April - July 2020, project adjustments expected by October 2020)

	Key Activity	Project Lead	Projected Completion Date
1.2.2	Continue system updates to support designed services from 1.2.1 ➔ Analyze and allocate organizational resources to align positions to support system goals. ➔ Revise, reduce, and automate documentation to reduce time spent on non-critical activities and be understandable to families and workers, starting with front-end services. ➔ Establish standard work for positions within the organization to ensure competency and alignment of work toward the goal of keeping children safe and strengthening families.	Project Coordinator	March 2021

Strategy 3: Implement system changes to improve efficiencies and support for families and caseworkers.

	Key Activity	Project Lead	Projected Completion Date
1.3.1	Broader system changes to support families and workers (Broader system improvements and relationship building) ➔ Reduce volume of practice guidelines to reflect current practice expectations and incorporate Standard Operating Procedures (SOP). ➔ Create quality assurance tools that match the services designed. This includes using status, process and outcome measures that are focused on achieving the goal. This includes adjusting our CQI processes to align with agency goals. ➔ Communication plan to notify agency staff of restructuring of practice guidelines.	Project Administrator and Project Coordinator	Systematic review and update guidelines and QA tools: March - Oct 2021, expected completion by Dec 2021

Cross-cutting Strategy 2: Leadership Academy

In analyzing the reasons for low scores in the CFSR it appears that the role of supervisors to ensure that policies are followed and practice is carried out in a consistent and sensible way was insufficient or absent in a number of cases. Sometimes caseworkers faced unusual or complex circumstances that required creative solution finding; sometimes connections between an observed risk (for example a substance using parent returning home from jail) and a need to intervene or at least re-assess were missed. The absence of experienced supervisors who know what to monitor and how to support and coach caseworkers was identified as an area needing improvement in some cases. Utah asserts that the right policies and practice model are in place (with some exceptions, see below), the guidance for creative solution finding and confidence may be lacking with some caseworkers. The need to strengthen the skills of supervisors to better monitor practice and support caseworkers in providing effective services to families consistently was prioritized.

Since 2017, all new DCFS supervisors are provided a mandatory 2-day New Supervisor Onboarding training. It is offered quarterly at the state office. It covers topics such as transitioning from peer to supervisor, human resource skills/tasks, ethics, using data reports, etc. While this training has been welcomed as a needed support for new supervisors, it doesn't cover the skills needed to ensure that the delivery of child welfare practice produces the desired outcomes of safety, permanency, and well-being for children and families consistently and across all cases. The Leadership Academy was developed to meet this need.

The first cross-cutting strategy, Operational Excellence, is expected to provide the tools and strategies to strengthen supervisors' abilities to manage daily practice while creating more capacity to do so. The Leadership Academy is expected to strengthen their role and skills so they can better guide practice, particularly when encountering complex cases and situations like those seen in the CFSR onsite review.

The material used originally in the development of the Utah Leadership Academy came from Indiana University, School of Social Work. It is based on training material from the National Child Welfare Workforce Institute (NCWWI). The work on revising the original material to meet the needs of Utah's child welfare workforce was done internally, primarily by the training team. The team created trainer manuals and participant manuals for each module, which are given to every participant.

Purpose: The purpose of the Leadership Academy training is to prepare leaders to engage in transformational leadership in order to:

- develop and implement effective leadership that integrates the mission, vision and values of DCFS
- create an environment that supports increased retention, positive morale, and a learning culture
- Utilize data to advance safety, permanency, and well-being for children, youth, and families

The participants of the Leadership Academy include all levels of region leadership, including region directors, associate directors, child welfare administrators, and direct line supervisors, with the ultimate goal of region leadership providing a support structure for supervisors of front line staff, and strengthening skills of supervisors to better monitor practice and support caseworkers in providing effective services to children and families consistently.

Methodology/Format: The Leadership Academy consists of four modules, two days long each: Module 1: Supervisor Foundation, Module 2: Supervisor as Manager, Module 3: Supervisor as Coach, Module 4: Supervisor as Team Leader. The 2-day trainings consist of one-on-one interactions, stand-up lectures, group activities and group discussions, as well as transfer of learning activities. The activities for each module are broken down into three categories:

1. Direct supervisor/supervising mentor tasks:

- May include policy topics.
- Also clarifying/explaining local office practice.

2. Team tasks:

- Concepts that need to be put into practice
- Implementing plans created in the classroom to better support your team.

3. Personal/professional development tasks:

- Tasks to help you learn and grow in your new role.

* Transfer of Learning Activities for each module are distributed at the end of each training and must be completed prior to arriving at the next scheduled training.

Goal 2: Advance management and leadership skills of supervisors to ensure consistency and quality of services to children and families. (P2, WB1, WB2, WB3)

Strategy 1: Revise existing Leadership Academy materials in order to reflect recent changes to practice. Roll out training to all DCFS supervisors across the state. Provide training to all new supervisors.

	Key Activity	Project Lead	Projected Completion Date
2.1.1	Revise existing Leadership Academy material to reflect recent changes to practice, including FFPSA and Operational Excellence implementation. Make sure that the training supports the current rollout of additional Operational Excellence activities.	Training Director	June 2020
2.1.2	Determine with region leadership the best roll out schedule for their region calendar.	Training Director	June 2020
2.1.3	Conduct the four Leadership Academy trainings for supervisors in all regions with the support of regional training managers.	Training Director	December 2020
2.1.4	Develop sustainability/CQI measures: ● Sustainability will be ensured by utilizing region training managers as management coaches. New supervisors will be provided Leadership Academy at the central office as part of their onboarding training or subsequent to it. Training sessions will be provided when there are sufficient new supervisors and administrators to hold a new academy (usually 10), anticipated 2-3 times a year. ● CQI activities will consist of pre- and post-training evaluations, and adaptation of training content and transfer of learning activities, based on feedback from participants. In addition, the CQI will track the transfer of learning from the acquisition of skills through participation in the Leadership Academy to the demonstration of those skills in frontline casework through QCR scores in key practice areas like Engaging, Teaming, Assessing, and Planning.	Training Director	December 2020

Safety Outcome 1

Utah identified a technical change needed to improve performance on Safety Outcome 1 - Item 1: *Timeliness of Initiating Investigations of Reports of Child Maltreatment*. At the time of the CFSR onsite review, Utah required a timely face-to-face contact within the allotted priority time frame with at least one child victim identified in the allegations of abuse or neglect. Other child victims were to be seen by the end of the CPS investigation. The CFSR did not measure compliance based on this Utah policy but instead required that all reported child victims be seen within the priority time frame set for the case in order to receive a "strength" rating. 80% of the cases reviewed received a "strength" rating. There were 41 cases applicable. Of the eight cases that did not receive a Strength rating, four cases had CPS investigations during the PUR where some but not all of the child victims were seen within the priority time frame. In other words, half of the ANI's were due to the difference in policy and without this difference, Utah would have met the target goal. Hence, Utah agrees that the requirement to see all child victims within the priority time frame is a sensible policy and has decided to change the state practice guidelines to reflect this.

DCFS has a number of measures in place to track compliance with the practice guideline of seeing child victims within the priority time frames and address lack of compliance. These measures include reviewing this requirement as part of the Case Process Review (CPR), pulling reports at the worker, supervisor, team, region and state level and addressing reasons for declines in performance, as well as using prompts and notices in the CCWIS system to alert administrators when compliance isn't met. Based on data Utah DCFS has been tracking for over 20 years, the agency is confident that Utah has remained near 90% compliance with its practice guideline for many years and has successfully addressed declines when they occurred. This is why the CPS Steering Committee decided that the following technical changes are the only strategies necessary to remedy the CFSR result on this indicator.

Goal 3: Ensure safety for all children through timely response to reports of child maltreatment (Safety Outcome 1)

Strategy 1: Strengthen safety by ensuring all alleged victims of maltreatment are seen within the defined priority time frames (Technical Strategy).

	Key Activity	Project Lead	Projected Completion Date
3.1.1	Change DCFS practice guidelines to require that all children identified as alleged victims be seen within the priority time frames.	CPS and Safety Coordinator	March 2019
3.1.2	Inform the DCFS CPS staff of the modified requirement. This was done through the quarterly *Mandatory Information Communication (MIC)* process which requires supervisors to discuss any changes to the practice guidelines with the caseworkers in their team. The new requirement was further discussed in regional administrative meetings.	CPS and Safety Coordinator	March 2019
3.1.3	SAFE will program ways to record and track meeting priority time frames on individual children.	SAFE, Evaluation, & Research Administrator	Programming to begin Oct 2020 - completion: July 2021
3.1.4	Modify reports in SAFE to measure CPS timeliness of first face-to-face, according to the modified practice guideline.	Data Team Director	July 2021
3.1.5	Assess fidelity: Measure timeliness of meeting priority with new SAFE reports and apply the current CQI process (share report with the regions, have them track compliance internally and address any declines, follow progress in state level Practice Improvement Coordinator meetings and address any identified causes at region or state level). In addition, use the CFSR/PIP case review data to track progress on Item 1 and analyze any barriers.	CQI Administrator	July 2021

Strategy 2: *Apply new priority time frames to all "additional information allegations" received during an open CPS case to strengthen safety for children (Technical Strategy).*

Another technical change was identified as a result of reviewing CFSR findings on Item 1. When intake receives referrals of possible child abuse or neglect while an existing CPS investigation is underway, that referral is added to the ongoing CPS investigation and the CPS caseworker is notified, but the practice guidelines don't require child safety to be assessed within a given time frame. Utah has decided that it is necessary to strengthen its practice guidelines by requiring a new face-to-face be completed with the alleged child victims within a new priority time frame in order to assess their safety.

	Key Activity	Project Lead	Projected Completion Date
3.2.1	Change DCFS practice guidelines to require that when information containing additional allegations of maltreatment pertaining to an existing open CPS investigation is received by intake, a new priority time frame is given for a new face-to-face with the alleged child victims. The worker will be required to meet that new priority time frame, in addition to meeting the previous ones on the case.	CPS and Safety Coordinator	March 2019
3.2.2	Inform DCFS CPS staff of the modified requirement. This was done through the quarterly *Mandatory Information Communication (MIC)* process which requires supervisors to discuss any changes to the practice guidelines with the caseworkers in their team. The new requirement was further discussed in regional administrative meetings.	CPS and Safety Coordinator	March 2019
3.2.3	SAFE will program new priority time frames to be applied on “additional information allegations” on existing CPS cases, as well as prompts to remind caseworkers.	SAFE, Evaluation, & Research Administrator	Programming to begin Oct 2020 completion: July 2021
3.2.4	Tracking timeliness of the face-to-face contact with child victims in CPS to assess their safety is already a common practice in Utah (see strategy 1). Since “additional information allegation” will be treated like other referrals, compliance with this requirement will be tracked through the same existing mechanism as described under strategy 1. In addition, the CFSR/PIP case review results can be analyzed to see if these additional referrals continue to be an issue.	SAFE, Evaluation, & Research Administrator	Ongoing after July 2021

Safety Outcome 2

Problem Exploration

For Safety Outcome 2, the issue that became apparent, when looking at the CFSR onsite review data on item 2: *Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry Into Foster Care* and item 3: *Risk and Safety Assessment and Management*, was **insufficient assessment of child safety throughout the life of the case and, in particular, at critical junctures**.

Areas that scored well on Item 3 were: Safety in the foster home (95%), during parent-child visits in foster care cases (91%), and the appropriate investigation and substantiation of reported maltreatment allegations (95-97%). Initial assessments of safety also scored quite high (85%).

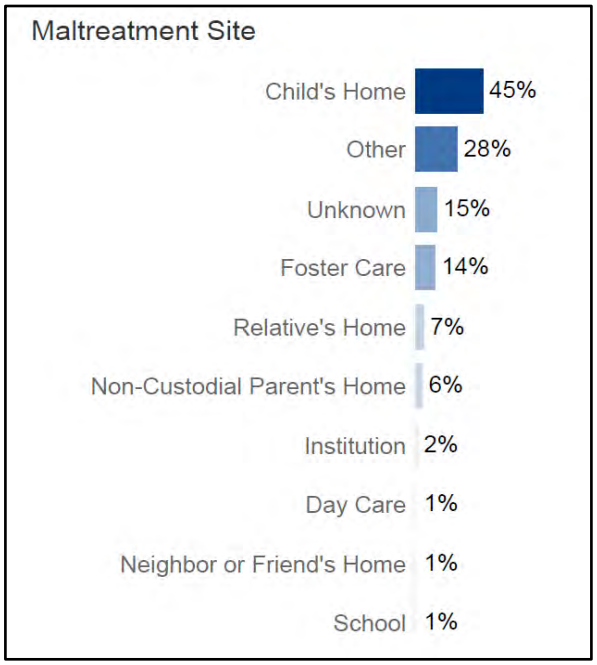
The main concerns noted in the onsite CFSR were with ongoing assessments (68%), appropriately addressing safety concerns (63%), and developing and monitoring safety plans (50%). Further analysis of the CFSR cases by the CQI team showed that the concerns centered on assessing and addressing the safety of children in their biological home, during in-home cases and during trial home placements in foster care cases. As the table below shows, this finding is significant and indicates that the focus of the strategies to address the issues in Safety Items 2 and 3 need to focus on when the children are in their home of origin, either in in-home cases or in foster care cases when returning home on a trial home placement or while they are visiting their parents.

CFSR Safety Item 2 and 3 Analysis

Where did the concern(s) take place (lack of assessing and/or addressing safety)?					
Item 3	**Did the agency make concerted efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care?**	62% (n=65, ANI=25)	**Item 2**	**Did the agency make concerted efforts to provide services to the family to prevent children's entry into foster care or re-entry after reunification?**	55% (n=20, ANI=9)
Analysis			**Analysis**		
	bio home/trial home placement/visits with bio parent	22		bio home	5
	Foster/Kin Home	3		return home	3
				kin home	1

Maltreatment in Foster Care Data Analysis:

Furthermore, analysis on Maltreatment in Foster Care data done by the data team of the Capacity Building Center for the States prior to the CFSR, which is one of the national data indicators that Utah is not meeting, confirmed these findings. When analyzing the cases of children who were supported victims of abuse or neglect while in foster care, it became clear that the majority of the cases (over 50%) were the result of abuse that happened in the child's home of origin or while in their non-custodial parent's home. In contrast the abuse that happened in the child's foster home represented only 14% of the cases (see graph on the right).



Utah requires that an initial assessment of safety, using the SDM Safety and SDM Risk Assessments, be completed during the CPS case. These are well incorporated into CPS practice and, to a certain degree, in In-Home cases, but the assessments are not well incorporated in foster care cases. The Safety Steering Committee identified that one of the most critical times to assess the safety and risk to the child is when his or her return home is anticipated. In Utah, the practice of using trial home placements (THP), where the child remains in foster care but returns to the home of the parent to live, is routinely used. The SDM Safety and SDM Risk Assessments can be completed at this time but are not required. The Safety Steering Committee, consisting of experienced child welfare staff, decided to further explore the practice of THPs.

A data set (five years of DCFS foster care data, from FY2014 to FY2018, of all cases that had a THP during that time) was sent to the Social Research Institute at the University of Utah, with whom DCFS has a partnership, for analysis on the use and outcomes of THPs. SRI conducted extensive analysis on the data, which showed, among other things, that very few cases (7.4%) had an SDM assessment done prior to the child returning home. Further analysis showed that conducting parent contacts prior to returning children home and visits done to the home during the THP were both correlated with a greater likelihood of success (success being defined as the case closing to a reunification and lower odds of repeat maltreatment or reentry in the following 12 months.) In Utah, neither visits to the home of the parent prior to the THP, nor a higher visit frequency once the child or children have returned home are required, though such visits are considered best practice. Based on these findings, the members of the Safety Steering Committee were in accord that addressing the lack of policy and practice around THP visits was the primary issue that needed to be addressed, with the understanding that quality visits to assess child safety in their home needed to be strengthened in all cases.

Root Cause Analysis:

The primary root cause identified by the Safety Steering Committee based on the above problem exploration is **insufficient quality visits to assess child safety in the home at critical junctures, in particular prior to and during Trial Home Placements**. Further exploration revealed that there are no practice guidelines in Utah requiring a particular frequency of visits prior to and during THPs, nor guidance or tools to inform the practice of conducting quality assessments of safety during home visits and record assessments in SAFE in a meaningful way. While addressing quality visits to assess children's safety in their homes is necessary in all cases and at all critical junctures, starting with Trial Home Placements is imperative because of the identified lack of policies and processes guiding the practice of returning children home safely. Therefore the following Theory of Change for Trial Home Placements was developed:

Theory of Change

Caseworkers have practice guidelines, guidance and/or tools to conduct quality visits which include a comprehensive assessment of safety in the home, in particular prior to and during THP.

- So that the frequency and quality of visits prior and during THP is appropriate to assess and address safety.
- So that quality assessments of safety in the home and addressing safety is happening in all THP.
- So that skills used to conduct quality assessments of safety during THPs are skills used in all home visits.
- So that safety is assessed and addressed in all home visits (in-home and foster-care cases) and at critical junctures.

Activities and Steps:

The frequency and quality of family contacts to assess safety prior to and during THPs was identified as the main issue. DCFS does not have any practice guidelines that require any particular visits or assessments prior to or during THP. Nor are there guidance or tools available for staff to know the right frequency of visits and how to assess safety prior to or during THP. The following adaptive strategy has been identified to address this problem:

- Based on existing data, identify a process to determine the right number of visits with the placement of origin needed prior to and during THPs. Write practice guidelines to reflect the requirements.
- Provide guidance and/or tools on how to do quality visits and quality ongoing assessments of safety during home visits.

- Create a systematic way for caseworkers to record their visit assessments in their logs (or in a way to not duplicate the logs).
- Establish a way for supervisors to mentor and monitor the frequency and quality of home visits prior to and during THPs.

While these strategies were originally aimed at caseworker visits prior and during THPs, it was decided that enhancing the skills of caseworkers to conduct comprehensive safety assessments of children living in their home during all visits was necessary. The following Goal 4 was expanded to include caseworker visits to the home where the children are living or returning to, with particular focus on critical junctures, not just in THP situations.

The goal of the cross-cutting strategy Operational Excellence is to incorporate this strategy and create the tools and processes that will ensure caseworkers complete quality assessments of safety before returning children home, during their THPs, and in any case *where children are living in their home of origin. This will be accomplished through Operational Excellence (phase II or later).*

Goal 4: Caseworkers have practice guidelines, standard operating procedures (SOP) and/or tools to conduct quality visits and complete comprehensive safety assessments of the home where the children are living or returning to. (Safety Outcome 2)

Strategy 1: Develop and implement practice guidelines, SOP, and/or tools for quality visits and safety assessments of homes where the children are living or returning to (Adaptive Strategy).

	Key Activity	Project Lead	Projected Completion Date
4.1.1	● The project development team researches existing tools around quality home visits and safety assessments. ● Develop a process (guidance, tools, practice guidelines) to ensure quality visits and completion of ongoing safety assessments in the home where the children are living or returning to. Select the best method of implementing this process so that frontline staff (caseworkers and supervisors) learn and successfully integrate the process of conducting quality home visits and safety assessments into their practice.	CPS and Safety Coordinator	October 2020
4.1.2	● The project development team will establish and implement a way for supervisors to mentor and monitor the frequency and quality of home visits and safety assessments in all in-home cases and when returning children home from foster care.	CPS and Safety Coordinator	October 2020
4.1.3	● The project development team, together with the CQI team, will develop measures and a CQI process to ensure that quality visits are conducted and safety is assessed before returning children home, during THPs, and in any case where children are living in their home of origin. These measures may include: Percent of in-home visits consistent with SDM recommendations; number and percent of SDM safety, risk and risk reassessments completed prior to sending children home and within required time frames; percent of private conversations with children for in-home and out-of-home cases monthly; and number of visits to the home of origin completed prior to and during THPs. Integrate these new measures into routine CQI processes at the region and state level.	CPS and Safety Coordinator and CQI Administrator	December 2020

Permanency Outcome 1

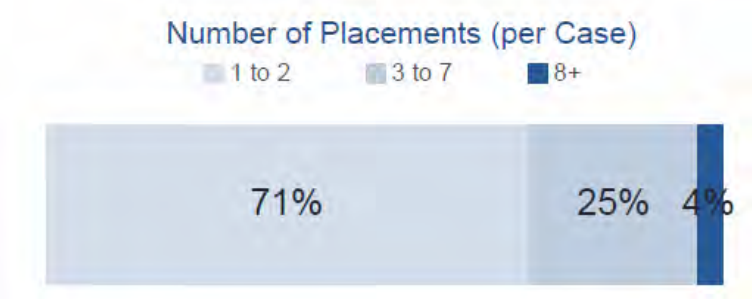
This outcome was one of the lowest scoring outcomes overall. While the outcome scored only 28% of the cases passing, the individual items scored higher: 48% on Item 4: *Stability of Foster Care Placements*, 77% on Item 5: *Permanency Goals*, and 58% on Item 6: *Achievement of Permanency*. Utah divided this outcome between a committee and a workgroup to explore the root causes and develop adaptive change strategies. *Placement Stability* was assigned to a DCFS Placement Stability workgroup. The other items, *Permanency Goal* and *Achieving Permanency* were more court related and were assigned to the Court Improvement Project (CIP) Committee.

Placement Stability

Problem Exploration

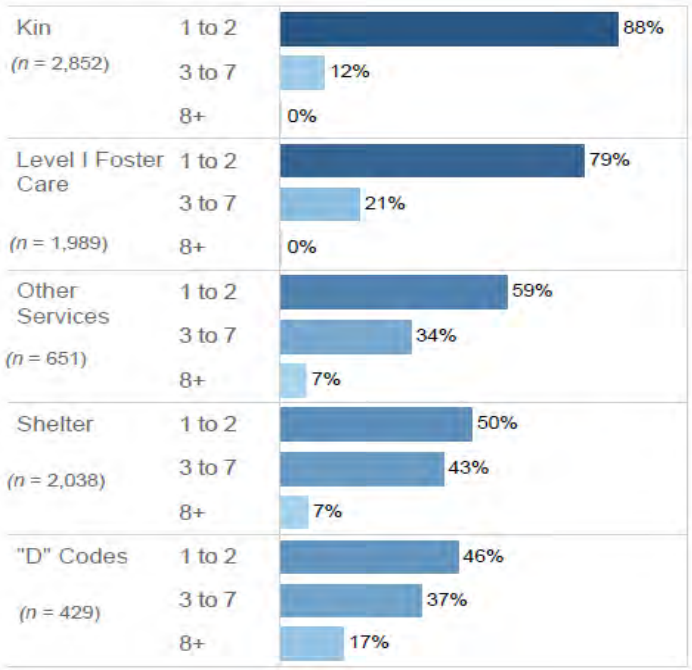
The Placement Stability workgroup consisted of internal staff from the state office and the regions. In the problem exploration phase, the workgroup held focus groups with placement providers and youth who are or were in foster care and reviewed national research provided by the Casey Foundation. In addition to reviewing CFSR results and findings from focus groups, the data below was analyzed.

Statewide foster care data on placement stability for July 1, 2013 to June 30, 2018 (5 years) was sent to the Capacity Building Center for the States (CBCS) data unit for analysis. The data included information on children in foster care beginning on or after July 1, 2013 and ended on or before November 1, 2018. The data did not include children who began their foster care episode prior to July 1, 2013 or who continued in foster care after November 1, 2018. The data analysis showed the following:



Total Number of Placements per Case

The data team from CBCS found the number of placements per case to be **2.4 placements**, which is a surprisingly low number of placements. The data further showed that 71% of the cases had one or two placements only and another 25% had between three to seven placements. The remaining 4% account for eight or more placements. This group of children is a concern to DCFS and contributes to the low placement stability scores in a significant way.



Placement Stability by First Placement, Child's Age, and Removal Reasons

This graph shows groups of children by their first placement. Among children who were placed with kin for their first placement, 88% experienced only one to two placements during their case. Whereas, children who were placed in a shelter or a "D" code placement (usually a congregate care setting) as their first placement were a lot less likely to experience placement stability.

Reasons for removal and child's age were also analyzed as related to the number of placements a child experienced. This analysis revealed that children who experienced a lot of instability were typically older and had entered foster care for reasons related to their behavior, such as delinquent behavior*, dependency, and ungovernable. Whereas, children who were removed for reasons related to their parents, such as neglect, physical abuse, and/or parent condition/absence, had greater placement stability throughout their case.

The data analysis further indicated that shelter placements, as a first placement or anytime throughout the case, correlates with a high placement instability. This is a correlation, not a direct cause of future instability. But the temporary nature of shelters contributes to a built-in move and as such is a factor in the number of moves.

For qualitative analysis, the committee obtained a separate data set and selected a number of cases where children had moved four or more times during their foster care episode. One child had 25 placements and four others had more than 20 placements. Committee members examined case records to determine the circumstances around the placement moves, looking for patterns and other information that could be used to identify reasons for instability in placements.

As mentioned above, the placement stability committee also obtained information from focus groups of placement providers including foster parents and provider agencies and youth who are or were in foster care through the Youth Council. A main placement stability concern identified by youth was the lack of communication concerning placement decisions. The committee determined that making sure youth are included in decisions about placements is an important need that needs to be included in strategies identified to address placement stability.

Root Cause Analysis:

Through the process of problem exploration, focus groups, and in-depth case reviews, the committee identified a number of issues that impacted the stability of foster care placements. The main root causes were: 1) Coding problems (how placements are recorded in the CCWIS system, resulting in incorrectly reported moves), 2) the use of shelter placements when a child is first removed and when placements disrupt, and 3) a lack of assessing foster parents' and kin caregivers' needs in caring for foster children in their home, communication with caregivers, and coordinating supports for them, particularly at critical junctures. This last reason clearly trumped the prior two. It came up repeatedly in focus groups with caregivers during and after the CFSR and when doing qualitative analysis of cases with multiple placement disruptions. The committee, using the systematic CQI process of problem exploration and root cause analysis, concluded that this was the most important problem underlying placement disruptions and needed to be the primary target. The committee identified several reasons for placement disruptions, including (a) insufficient information and preparation of foster and kin caregivers prior to placement; (b) not including the youth sufficiently in the placement decision (when old enough to do so), (c) caregivers not feeling comfortable or empowered to express their needs during home visits and team meetings until it's too late; (d) caseworkers not responding when placement issues were brought up, and (e) team meetings focusing more on the parents' services than the caregivers needs. etc. However, the main cause identified was that there is no process in place for a systematic and ongoing assessment of placements prior to and during.

The committee decided that the primary focus must be on **better assessment of out-of-home caregivers and provision of supports and services available for them.** In regards to the overuse of shelters, the committee agrees that shelter placements are a concern, but came to the conclusion that DCFS needed to focus on placement support and strengthening kinship involvement. The use of shelters should decrease by focusing on better selection of placements and supporting those placements to reduce disruptions that result in shelter placements. With the second phase of Operational Excellence, the agency will focus, among other things, more attention and resources during the CPS phase in order to prevent the removal of children from their homes or find kinship placements for them, avoiding shelter care. The plan includes strengthening the practice of conducting team meetings before or at the time of removal in order to identify possible kinship placements, in order to build a team early in the case and avoid placing children in a temporary shelter. This should naturally decrease the use of shelters as a first placement. Additional focus will also be placed on identifying and involving kin early in in-home cases. In addition to added support, in the event of a removal, the child(ren) will be more likely to be placed with kin.

Another technical solution is to **fix coding issues identified in Utah's CCWIS system that result in incorrectly counted placement changes,** in particular respite stays counted as formal placements, resulting in an incorrect total number of placements. These fixes are expected to be done by April 2020.

Theory of Change

One of the main root causes identified for placement instability is: OOH caregivers lack supports to maintain placements.
A theory of change includes a series of causal links. The Pathway of causal links for the Theory of Change for placement stability is:

Utah will strengthen placement stability and improve supports to OOH caregivers by …

Actively including children and their families in the ongoing assessment of the placement and ensuring families have a voice in the placement decisions, with kinship placements being the priority. The standard of practice will be defined by those "receiving" the service or support.

And...
Creating and providing a structure for caseworkers to assess the needs of OOH caregivers and children in their homes on an ongoing basis.

And...
Creating and providing a structure for supervisors to monitor and support caseworkers in an ongoing assessment of OOH caregiver needs and provision of supports.

And...
Ensuring the Child and Family Team plays an integral role in planning for stability and transitions, continuously assessing OOH caregivers' needs and directing the supports to preserve placements.

And...
Providing OOH caregivers with an array of timely supports and services to help maintain or select the best placement.

Then...
OOH caregivers will have the necessary information about the child(ren) before placing them in their home.

Then...
Everyone will understand that caring for foster children is difficult and that being a foster child is difficult.

Then...
OOH caregivers will feel comfortable expressing their struggles and needs to DCFS.

Then…
OOH caregivers and families will work together to best meet the needs of the children.

And...
There will be a better understanding of the OOH caregivers' needs in caring for these children.

So that…
OOH caregivers are confident in their ability to care for the children.

So that…
All children have stability in their out-of-home placements.

Goal 5: Foster parents and kin caregivers have the necessary supports to successfully care for the children placed in their home resulting in improved placement stability for children in foster care. (Permanency 1)

Children and their families need to be actively included in the ongoing assessment of the placement and have a voice in the placement decisions with kinship placements being the priority. The standard of practice (Full-Kit for placement determination) should be defined by those “receiving” the service or support. A full-kit may include documents, resources, identified supports, protocols, and procedures.

Utah uses the Child and Family Team as the primary structure to involve parents and children in the decisions made in their case. The team, including the family, meet on a regular basis (usually every three months, sometimes more) to review progress and make adjustments to plans. This was recognized in the Onsite CFSR and reported by stakeholders as a key tool to facilitate family voice and a major strength in Utah’s child welfare practice. While the structure is there, strengthening the process to improve placement decisions and support is the primary purpose of this goal.

Strategy 1: The agency develops a structure for caseworkers to assess and meet the needs of OOH caregivers and children in their homes on an ongoing basis and for supervisors to monitor and support caseworkers in these efforts (Adaptive Strategy).

	Key Activity	Project Lead	Projected Completion Date
5.1.1	Develop a Full-Kit for out-of-home caregivers and kinship caregivers to ensure they have the information, resources, and rapid support to navigate the system when placing a child in an out of home placement. Full-kits will include the materials/products/information needed to navigate the system. The kits will be developed with the input of foster and kinship families. One piece that was developed and deployed in August is a brochure for foster and kin parents that they receive at the beginning of a case with helpful information and links. To refine and further develop the full kit, stakeholder meetings with parents, kinship providers, kinship staff, and caseworkers, licensed foster parents, Utah Foster Care Foundation, RFCs, WWK, and caseworkers will be held, as part of the CQI process (for example, revising the website by adding an FAQ section).	Practice Administrator and Kinship /Foster Care Coordinator	July 2020 (Design), completion October 2020
5.1.2	Develop a process/system to support the team in choosing the best placement the first time, with prioritizing kin in the selection of that placement and avoiding shelter placements. Assess on an ongoing basis the appropriateness of that placement and any following placements. This process will create a standard of practice to set expectations for supervisory monitoring of this process. (e.g., case staffings, reviewing cases).	Practice Administrator and Kinship /Foster Care Coordinator	Development start October 2020 Completion February 2021

	Key Activity	Project Lead	Projected Completion Date
5.1.3	The Child and Family Team plays an integral role in planning for stability and transitions, continuously assessing OOH caregiver, youth and family needs, and directing the supports to preserve placements. Key activities include: ● The development of a teaming Full-Kit for caseworkers and team members that addresses placement stability. The Full-Kit will be defined and developed by stakeholders. ● Youth and family will take an active role in the decision making process with the goal of a youth and family leading the discussion. ● The teaming Full-Kit will include a process for the youth to safely discuss placement options or issues regarding current placement. The team will ask the youth about their preferences in the characteristics of the placement. ● The team will take into consideration the youth's voice and their long term best interest.	Practice Administrator and Kinship /Foster Care Coordinator	Development and and roll-out March-July 2021,
5.1.4	Develop an array of timely services to help select, maintain and support placements. These efforts will be coordinated with Service Array strategies described under Systemic Factors. (1) Need to identify and/or develop "immediate" and "ongoing" supports and services (e.g crisis mobile response vs. long term service). (2) Identify and define each team member's role in responding to the needs of the OOH caregiver (e.g., caseworker, kinship worker, RFC, foster care providers, WWK, and after hour needs). (3) Youth will be encouraged to build their own informal support system. The teams will work through potential barriers in order to maintain the youths' identified support network.	Practice Administrator and Kinship /Foster Care Coordinator, Director of Office of Quality and Design (OQD)	Development and initial roll-out July-Dec 2021, ongoing service array development
5.1.5	Create a CQI process to measure the success of this strategy. This CQI process will be developed to ensure that the strategy is successful and can be sustained. It will include the creation of a new placement stability measure so that data can be analyzed, as well as ongoing tracking of shelter usage.	Practice Administrator and Kinship /Foster Care Coordinator	Developed by August 2021, then ongoing

The committee recognized that further development of these activities requires participation of foster and kin caregivers at various levels, as well as caseworkers and those providing support/services. Until these groups have been consulted, the steps remain broad and will need more development to further inform these strategies.

Permanency Goal and Timely Permanency

Root cause analysis/Theory of Change

The CFSR identified that the main problem on Item 5 - *Permanency Goals* - was that the concurrent goal was not appropriate or not being worked on. There were also problems with changes in goals not occurring in a timely manner. This resulted in Item 5 scoring 77%. Item 6: *The achievement of permanency* - scored 58%. For several years, data reports from the courts have shown that the frequency and timeliness of hearings on foster care cases in Utah was not the issue, with most cases having a hearing every 90 days. As information was examined during a CIP committee meeting, three root causes for delays in achieving permanency emerged: 1) Continuances, 2) 90-day reunification extensions, and 3) Permanency Hearing Quality. Questions about these three possible root causes were formulated by the members of the CIP committee. The next step for the CIP committee was to gather data to inform the questions.

A survey on how often permanency and concurrent goals are reviewed in court hearings went out to judges and legal partners, including Assistant Attorneys General (AAG), Guardian ad Litem (GAL), and Parental Defense Attorneys (PD). There was a 90% response rate, with 28 of 31 juvenile court judges completing the survey. All judicial districts were represented in the responses.. Legal partners were also well represented with an overall completion rate of 83%. Less than a ¼ of the attorneys who responded reported that a review of the permanency goals occurred at every court hearing, regardless of whether or not the goal had changed. Judges believe that "meaningful conversations" occur in permanency hearings more often than attorneys do. Both attorneys and judges believe that meaningful discussions happen even less frequently during review hearings than during permanency hearings.

The results showed that:

- Permanency goals are not reviewed at every court hearing.
- A meaningful conversation about the appropriateness of the concurrent permanency goal does not happen at every hearing.

In addition, data from the DCFS SAFE system on conditions and timeframes for reunification were examined.

The survey data along with the DCFS administrative data was the basis for a workshop sponsored by the Capacity Building Center for the Courts in Denver, January 14 and 15, 2019. The workshop brought together four DCFS administrators including the DCFS Director, three members of the Federal Operations and CQI team, and six members of the juvenile court, including the chair of the CIP committee (a juvenile court judge), the Deputy Director of the Attorney General's Child Protection Division, two administrators from the Administrative Office of the Juvenile Court who work directly with the CIP, the Board President of the Utah Parental Defense Alliance, and the Office of the Guardian ad

Litem Director. Information from Dr. Sophie Gatowski's report of a growing body of evidence nationally, which shows a linkage between the quality of hearings and permanency outcomes, was examined. The research showed that when there is a more thorough discussion at hearings it appears to shorten time to permanency. In addition, parent presence at hearings appears to be related to increased rates of reunification. The National Council of Juvenile and Family Court Judges (NCJFCJ) Enhanced Resource Guidelines articulate best practice guidelines for high quality hearings.

Based on the data examined, the CIP workgroup agreed that juvenile court hearings in Utah are not as effective as they could be in identifying the appropriate permanency goal(s) and achieving them timely. The group further agreed to focus on improving the quality of discussion at hearings. Improving this will contribute to more quality hearings where parties are engaged so that everyone understands the family's current circumstances and the path to permanency, including next immediate steps, so that children and families achieve timely and appropriate permanency.

The group developed a Theory of Change with this statement as the final revision:

Theory of Change

We will improve the quality of hearings ……

- ➔ so that all participants are engaged in respectful hearings in a way that fosters hope and continued participation.
- ➔ so that each hearing will sufficiently cover pertinent Safety, Permanency, and Well Being factors with depth and breadth resulting in more meaningful hearings.
- ➔ so that all parties clearly understand the family's current circumstances at each hearing.
- ➔ so that an appropriate goal[1] is established timely and evaluated on an ongoing basis.
- ➔ so that all parties clearly understand the path to permanency and what is needed to achieve permanency including immediate next steps.
- ➔ so that each hearing contributes meaningfully in a clear progression towards Permanency.
- ➔ so that children and families achieve timely and appropriate Permanency (P1, Items 5 and 6).

[1] *A Permanency goal includes concurrent permanency goals.*

Utah learned that all Hearing Quality studies examined the use of a judicial benchcard and that multidisciplinary training on the benchcard reinforces the expectations for the hearings. The next step was to look for existing benchcard research and other state's interventions. Dr. Sophie Gatowski provided both. The CIP committee met on March 29, 2019 to develop the necessary steps, which are expected to result in the development and implementation of the Utah Juvenile Court Quality Hearing Benchcard. The CIP committee also believes that the Quality Hearing project will address the issue of concurrent permanency goals not being accurate or not being worked on. The benchcard / tools will include prompts to remind judges and court hearing participants to discuss both the primary and concurrent permanency goals. The expectation is that staff will use the tools to guide discussions in team meetings prior to court hearings so that the appropriateness of permanency goals is addressed before hand.

Goal 6: The quality of juvenile court hearings in foster care cases is such that participants feel engaged and respected, that appropriate permanency goals are established in a timely manner and reviewed regularly, and hearings contribute to the timely achievement of permanency for children in foster care across Utah. (Permanency 1)

Strategy 1: Develop and Implement Quality Hearing Benchcard (for judges) and Guide for Utah's juvenile courts (for all parties attending court hearings and their attorneys) (Adaptive Strategy).

	Key Activity	Project Lead	Projected Completion Date
6.1.1	Develop benchcard and guides: - CIP forms workgroup to develop Quality Hearing Guide and Benchcard - Decide who must review/approve - Look at existing BC research and other states' interventions - Draft UT Quality Hearing benchcard and guide - Get input from stakeholders, Family Voice - CIP reviews and revises Benchcard and guide - Get final approval	CQI Coordinator and CIP	March 2020
6.1.2	Readiness and Site Selection: - Select a readiness assessment tool/approach - Collect the data from readiness assessment and review the results - Determine jurisdictions to implement/ready to embrace strategy	CQI Coordinator and CIP	August 2020
6.1.3	Shared Vision and Buy In (Marketing Plan): - Create fact sheet - Present project to Board of Juvenile Court Judges and get their buy-in - Take to Judges, GAL, and Defense to obtain judicial buy-in on value of the idea - Identify Champions - Formulate strategy to develop buy-in from legal/judicial partners, DCFS, and Foster Parents	CQI Coordinator and CIP	Initial Marketing Plan: May 2020 Obtaining buy-in from judges and other legal partners: Ongoing

	Key Activity	Project Lead	Projected Completion Date
6.1.4	Professional Support (Training) for legal/judicial and DCFS staff: - Draft training timeline, including training of pilot site staff. - Look for other states' training curriculum - Create training curriculum - Decide who does the training and who receives it - Use statewide conferences to provide training - Plan to distribute the Quality Hearing guide/tools to DCFS staff and train them on how to use them. *Training should take place for DCFS staff and legal partners at the same time so that everyone understands the purpose of these tools and how to use them to prepare for court hearings and make them more effective. The workgroup will need to explore ways to that.*	CQI Coordinator and CIP	Pilot Site Training: August 2020 Statewide Training: August 2021
6.1.5	Does This Work? (Evaluation) - Identify what will be evaluated, including outcomes to measure (formative: how is it implemented; summative: did we achieve outcomes?) - Develop evaluation methods (such as observations, surveys, outcome data, etc.) - Identify resources for evaluation (i.e. $ for contract, staff, etc.) - Conduct evaluation - Implement feedback loop and adapt as needed - Explore and implement ways to build continuous learning opportunities for legal/judicial and DCFS staff.	CQI Coordinator and CIP	Pilot Evaluation: April 2021 Statewide Evaluation: April 2021 to August 2022*

** Some CQI pieces, like pre- and post surveys, are intended to be completed prior to and during implementation to make sure the project is implemented as intended and to gather input from participants. Long term pieces, such as analyzing outcome data to see if the project has an impact on permanency outcomes, takes longer and requires cases to be closed to see if the children achieved permanency in a more timely manner.*

Systemic Factors

Service Array and Resource Development

The data gathered in preparation for the Statewide Assessment and stakeholder interviews during the CFSR showed that although there is an adequate array of services in Utah, access to these services is limited in some jurisdictions of the state, especially in the rural areas. Stakeholder interviews indicated that in these areas, there is a need for more foster homes, mental health services, substance abuse treatment services, domestic violence services, affordable housing, and public transportation. Additional barriers include waitlists and the distance families have to travel to access services. Stakeholders reported that adopted children have had to enter care to receive needed services because post-adoptive services are lacking in some areas of the state. Stakeholders also reported a lack of culturally competent services for Native Americans or for families who speak languages other than English.

Stakeholder interviews are conducted annually in every region by the Office of Quality and Design as part of the QCR. The summary of these interviews is presented to each region administration after their review and included in their QCR report in order for them to address issues in their purview. It helps identify gaps in service availability and increase staff understanding about the array of services available to serve their clients. This system of gathering and sharing information about service array locally will continue based on region feedback.

Issues of accessibility and availability of services, particularly in the rural parts of the state, have been at the forefront of the agency and department's priorities, even prior to the CFSR. The adoption of a System of Care program at the department level was a department approach helping families with children having high-level-needs that require cross-division services. As a result of this System of Care, a need to streamline services across divisions and eliminate barriers was identified. This resulted in an Integrated Service Delivery initiative aimed at addressing missing services and strengthen existing ones and ultimately resulted in the creation of the **Office of Quality and Design (OQD).**

The belief that the department needs to better engage families and stakeholders in designing services and evaluating these services is a key principle underlying the formation of this new office. OQD has been tasked with the following responsibilities, in addition to their ongoing tasks of writing and managing contracts, procurement, develop and manage provider networks, evaluate services, measure outcomes, and refine services:

- Seek and organize inputs on gaps and needs
- Coordinate the prioritization of service needs
- Research solutions

- Facilitate the design of new services and the refinement of existing services (with program specialist and stakeholder engagement)
- Provide written guidelines for services and provide technical assistance
- Ensure a broad, flexible array of effective services

OQD has only been in existence for about one year, so processes are still being developed. Efforts by OQD to gather information regarding gaps in services provided by the department so far include the following:

- A gap analysis coordinated by the courts (Judge Noonan's working group) in conjunction with juvenile justice reform.
- System of Care evaluation of gaps with Regional Advisory Councils and through attempts to access services in implementing the System of Care initiative.
- An assessment of existing Evidence-Based Programs within the public mental health and DCFS systems.

OQD is making further attempts to assess gaps. They have done it for Juvenile Justice Services (JJS), which included looking at caseworkers' knowledge of existing services. OQD plans to find out more about the utilization and knowledge of services and how individualized they are. They also use national research from SAMHSA about the five core services that are essential to good systems (peer support, respite, intensive in-home services, high fidelity wrap-around services, mobile crisis stabilization). Next steps: based on all identified gaps, based on national research/guidance, identify what the areas are to focus on and work with providers to improve the array of services provided in all jurisdictions. Then, work with the divisions to prioritize which service gaps to focus on and work with providers to increase access. Several initiatives to address the issues mentioned in CFSR stakeholder interviews have started or are being planned for the future.

Current OQD Initiatives:

OQD is currently working on several initiatives aimed at improving the availability and accessibility of services to families served by the department. These include:

- Integrated Clinical and Non-clinical Wrap Services contract (started in July 2018): *This is a contract that combined multiple previous procurements for the department's clinical mental health and nonclinical support services. The contract integrated provider networks that were previously siloed within each DHS division and fragmented and accessibility depended on which door a child and family entered. These contracts are now integrated - all services are available to children and families involved with DHS, regardless of the division they are working with and regardless of custody status. New services were also added through this contract (such as family and youth peer support services), requirements were streamlined, and a greater emphasis was placed on work with families.*
- Incentives for rural areas
- Enhanced rates for evidence-based "in-the-home-treatment"

- Telehealth platform that all providers can use
- Clinical and wrap services for youth in foster care available to youth living at home
- Clinical and non-clinical supports/services available to youth and families who are in probation but are not in JJS or DCFS custody.
- Crisis mobile service (SMR) available in some areas, as a 24-hour crisis intervention service accessible for the community including foster parents and kinship caregivers.
- Expansion of Evidence-Based Programs for children, youth and families involved with DCFS.

OQD is partnering with DCFS and other agencies in the department to strengthen Utah's Service Array:

Goal 7: Families and their children involved with DCFS have access to an array of evidence-based services and programs that will enable children to remain safely in their homes or in the homes of their relatives and will enable children in foster care to achieve permanency. (Service Array)

Systemic Factors - Service Array

Strategy 1: Expand the array of evidence-based services and programs for children, youth and families involved with DCFS, including kinship caregivers, as components of Family First Prevention Services Act implementation for prevention services and kinship navigator services.

	Key Activity	Project Lead	Projected Completion Date
7.1.1	Explore possible evidence-based services to be included in Utah's Title IV-E prevention program plan, including identification of services being reviewed by the Prevention Services Clearinghouse and services that could be reviewed using the Transitional Payment Review process.	OQD (Quality and Design) Administrator and SUD/In-Home/Reunification Coordinator	Oct 2019 for initial plan; ongoing for future expansion
7.1.2	Assess the extent to which EBP services are currently available in the state through DHS contracts with community providers, local mental health and substance use disorder authorities, etc.	OQD Administrator and SUD/In-Home/Reunification Coordinator	Aug 2019 for initial plan; ongoing for future expansion
7.1.3	Survey community providers to determine the extent of interest in receiving training in new evidence-based programs or services.	OQD Administrator and SUD/In-Home/Reunification Coordinator	Aug 2019 for initial plan; ongoing for future expansion
7.1.4	Provide funding and coordinate training for selected new EBPs for inclusion in Utah's Title IV-E prevention program plan initially and for future expansion.	OQD Director and SUD/In-Home/Reunification Coordinator	June 2020
7.1.5	Contract for selected EBPs that are included in Utah's approved Title IV-E prevention program plan initially and for future expansion, and for a future evidence-based kinship navigator program.	OQD Director and SUD/In-Home/Reunification Coordinator	Oct 2019 for initial plan; ongoing for future expansion
7.1.6	Implement the CQI and evaluation activities included in the IV-E prevention program plan.	OQD Director, CQI Administrator and Federal Operations Administrator	June 2021

Systemic Factors - Service Array

Strategy 2: *Enhance access to clinical and non-clinical wraparound services for children, youth, and families, which may also include kinship caregivers; expand the number of providers contracting to provide these services under the Integrated Clinical Wrap Services contract, if necessary (started in July 2018); and implement strategies to expand availability, especially in rural areas.*

	Key Activity	Project Lead	Projected Completion Date
7.2.1	Establish incentives for rural areas.	OQD Director and Finance Director	Dec 2019
7.2.2	Enhance rates for evidence-based services included in the prevention plan, as needed to support increased requirements to sustain fidelity.	OQD Director and Finance Director	Dec 2019
7.2.3	Implement a telehealth platform that will be available for any contracted providers to use. The platform has been set up, providers are in the process of being signed up.	OQD Administrator and TAL and Adoption Coordinator	Oct 2020
7.2.4	Use the process of obtaining feedback and assessing service gaps, described in the following strategy (Strategy 3, in particular 7.3.3) to evaluate the effectiveness of these measures and make adjustments as needed.	OQD Director and Finance Director	Oct 2020

Systemic Factors - Service Array

Strategy 3: Explore methods to assess service gaps and needs, including problems with access, on an on-going basis throughout the state. Identify and prioritize regional gaps with local stakeholders. Facilitate development of identified services.

	Key Activity	Project Lead	Projected Completion Date
7.3.1	Develop a map of service needs based on historical DCFS UFACET client data.	OQD Director and SUD/In-Home/ Reunification Coordinator	Dec 2019
7.3.2	Based on service needs map, identify potential service gaps.	OQD Director and SUD/In-Home/ Reunification Coordinator	Dec 2019
7.3.3	Establish a process to obtain feedback from regions to confirm and prioritize service gaps and needs. Feedback may be sought from designated region points of contact, region System of Care committees, focus groups, surveys, offices, teams, clients, and other stakeholders. Feedback will be used as a guide for planning and to inform the Department's development efforts in service array expansion.	OQD Director and SUD/In-Home/Reunification Coordinator	Process in place by February 2020; continues ongoing.

DCFS believes that these three initiatives will significantly contribute to the development and strengthening of the array of services to help families served by the agency, though some of the results may take several years to be fully realized across the state. For example, encouraging service providers to elevate their services to an evidence-based level (as required by the FFPSA) will take years and will be an ongoing effort as research projects are developed and training and guidance is offered to interested providers. The fact that these services will become more and more available over time to prevent children from coming into care is expected to improve not only this Systemic Factor, but also Safety 2 - *Services to Maintain Children in their Homes*.

Continuing to encourage providers to apply for contracts under the Integrated Clinical Wrap Services contract will help families whose children are at home or with foster parents, in particular kinship caregivers. This should strengthen *Placement Stability* (Item 4) and Item 12 - *Services to Children, Parents, and Foster Parents,* in addition to Service Array.

Finally, developing a method to assess service gaps on an ongoing basis will be essential to track what's needed and where, so that community partners can be engaged in addressing those gaps and incentives can be created to encourage the strengthening of existing services or developing new ones.

DCFS and OQD are engaged in ongoing meetings to work on these goals and will continue to collaborate closely on this plan.

[The measurement plan has been deleted in its entirety at the request of the Children's Bureau.]

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