Child and Family Services Reviews

Statewide Assessment Instrument

April 2014

Connecticut Department of Children and Families' Submission

March 25, 2016

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN & FAMILIES
Administration on Children, Youth and Families
Children's Bureau

This page was intentionally left blank.

Table of Contents

This page was intentionally left blank.

Introduction

The Child and Family Services Reviews (CFSRs), authorized by the 1994 Amendments to the Social Security Act (SSA), are administered by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. The goals of the CFSR are to:

- Ensure substantial conformity with title IV-B and IV-E child welfare requirements using a framework focused on assessing seven safety, permanency, and well-being outcomes and seven systemic factors;
- Determine what is happening to children and families as they are engaged in child welfare services; and
- Assist states in helping children and families achieve positive outcomes.

The CFSR Process

The CFSR is a two-phase process, as described in 45 CFR 1355.33. The first phase is a statewide assessment conducted by staff of the state child welfare agency, representatives selected by the agency who were consulted in the development of the Child and Family Services Plan (CFSP), and other individuals deemed appropriate and agreed upon by the state child welfare agency and the Children's Bureau.

The second phase of the review process is an onsite review. The onsite review process includes case record reviews, case-related interviews for the purpose of determining outcome performance, and, as necessary, stakeholder interviews that further inform the assessment of systemic factors. The onsite review instrument and instructions are used to rate cases, and the stakeholder interview guide is used to conduct stakeholder interviews.

Information from both the statewide assessment and the onsite review is used to determine whether the state is in substantial conformity with the seven outcomes and seven systemic factors. States found to be out of substantial conformity are required to develop a Program Improvement Plan (PIP) to address the identified areas out of substantial conformity. States participate in subsequent reviews at intervals related to their achievement of substantial conformity. (For more information about the CFSRs, see the *Child and Family Services Reviews* at http://www.acf.hhs.gov/programs/cb.)

Integration of the CFSP/APSR and CFSR Statewide Assessment

The CFSR process is intended to be coordinated with other federal child welfare requirements, such as the planning and monitoring of the CFSP. We are encouraging states to consider the statewide assessment as an update to their performance assessment in the state's most recent CFSP and/or Annual Progress and Services Report (APSR) rather than a separate assessment process and reporting document. Most of the content for the statewide assessment overlaps with the CFSP/APSR and the same expectations for collaboration with external partners and stakeholders exist across all planning processes. States can use the statewide assessment process to re-engage these partners and stakeholders in preparation for the CFSR.

The Statewide Assessment Instrument

The statewide assessment instrument is a documentation tool for states to use in capturing the most recent assessment information before their scheduled CFSR. Each section, as outlined below, is designed to enable states to gather and document information that is critical to analyzing their capacity and performance during the statewide assessment phase of the CFSR process.

- Section I of the statewide assessment instrument requests general information about the state agency and requires a list of the stakeholders that were involved in developing the statewide assessment.
- Section II contains data profiles for the safety and permanency outcomes. These include the data indicators, which are used, in part, to determine substantial conformity. The data profiles are developed by the Children's Bureau based on the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS), or on an alternate source of safety data submitted by the state.
- Section III requires an assessment of the seven outcome areas based on the most current information on the state's performance in these areas. The state will include an analysis and explanation of the state's performance in meeting the national standards as presented in section II. States are encouraged to refer to their most recent CFSP or APSR in completing this section.
- Section IV requires an assessment for each of the seven systemic factors. States develop these responses by analyzing data, to the extent that the data are available to the state, and using external stakeholders' and partners' input. States are encouraged to refer to their most recent CFSP or APSR in completing this section.

We encourage the state to use this document "as is" to complete the assessment, but the state may use another format as long as the state provides all required content. The statewide assessment instrument is available electronically on the Children's Bureau website at http://www.acf.hhs.gov/programs/cb/resource/round3-cfsr-statewide-assessment.

Completing the Statewide Assessment

The statewide assessment must be completed in collaboration with state representatives who are not staff of the state child welfare agency (external partners or stakeholders), pursuant to 45 CFR 1355.33 (b). Those individuals should represent the sources of consultation required of the state in developing its title IV-B state plan and may include, for example, Tribal representatives; court personnel; youth; staff of other state and social service agencies serving children and families; and birth, foster, and adoptive parents or representatives of foster/adoptive parent associations. States must include a list of the names and affiliations of external representatives participating in the statewide assessment in section I of this instrument.

We encourage states to use the same team of people who participate in the development of the CFSP to respond to the statewide assessment. We also encourage states to use this same team of people in developing the PIP. Members of the team who have the skills should be considered to serve as case reviewers during the onsite review.

How the Statewide Assessment Is Used

Information about the state child welfare agency compiled and analyzed through the statewide assessment process may be used to support the CFSR process in a range of ways. The statewide assessment is used to:

- Provide an overview of the state child welfare agency's performance for the onsite review team;
- Facilitate identification of issues that need additional clarification before or during the onsite review;
- Serve as a key source of information for rating the CFSR systemic factors; and
- Enable states and their stakeholders to identify early in the CFSR process the areas potentially needing improvement and to begin developing their PIP approach.

Statewide Assessment Instrument

Section I: General Information

Name of State Agency: Connecticut Department of Children and Families

CFSR Review Period

CFSR Sample Period: April 1, 2015 – September 30, 2015

Period of AFCARS Data: Varies by Statewide Data Indicator, ranging from FFY12B – FFY15A

Period of NCANDS Data: Varies by Statewide Data Indicator, ranging from FFY13 – FFY14

(Or other approved source; please specify if alternative data source is used):

DCF SACWIS (LINK), DCF ROM Reporting, DCF Provider Information Exchange and DCF ACR Reporting

Case Review Period Under Review (PUR): April 1, 2015 to Date Review Completed (ranging from April 1, 2016 – September 30, 2016)

State Agency Contact Person for the Statewide Assessment

Name: Susan R. Smith

Title: Chief of Quality and Planning

Address: 505 Hudson Street, Hartford, CT 06106

Phone: 860.550.6695

Fax: 860.560.7086

E-mail: susan.smith@ct.gov

Statewide Assessment Participants

Provide the names and affiliations of the individuals who participated in the statewide assessment process; please also note their roles in the process.

State Response:

Insert names and affiliations of statewide assessment participants

Susan R. Smith – Department of Children and Families: Author

Fernando Muniz - Department of Children and Families: Reviewer + Contributor

Elizabeth Duryea - Department of Children and Families: Contributor

Jodi Hill-Lilly- Department of Children and Families: Contributor + Reviewer

Lynette C. Warner - Department of Children and Families: Reviewer + Contributor

Treena Mazzotta - Department of Children and Families: Author + Reviewer

Fred North - Department of Children and Families: Contributor + Reviewer

Sarah Gibson - Department of Children and Families: Author + Contributor

Valter Borges - Department of Children and Families: Author + Contributor

Tracy Davis - Department of Children and Families: Author, Reviewer + Contributor

Wanda Ladson – Department of Children and Families: Contributor

Dawn Anderson - Department of Children and Families: Contributor

Kim Nilson - Department of Children and Families: Contributor

Tom Ranallo- Department of Children and Families: Contributor

Syndia Serrano-Urso- Department of Children and Families: Author

Jennifer Sisk- Department of Children and Families: Author + Contributor

Michelle Massores – CT Court Operations (Judicial): Author + Contributor

State Advisory Council – diverse membership including, regional community representatives: Standing agenda items including regional and DCF updates, and annual retreat supported receipt of input regarding areas of concern and system strengths. Two dedicated CFSR presentations also provided to the SAC. Please know that attendance at SAC meetings varies. Therefore, specific participants have not been noted.

Section II: Safety and Permanency Data

State Data Profile

(CB-generated state data profile will be inserted here)

Insert state data profile—CB-generated data profile of safety and permanency data

Connecticut

CFSR 3 Data Profile

Children's Bureau
An Office of the Administration for Children & Families

November 2015

Submissions as of 08-19-15 (AFCARS) and 09-25-15 (NCANDS)

CFSR Statewide Data Indicator Performance & PIP Status	12 month period	Data Used	Observed Performance			Risk-Standardized Performance (RSP) & National Standard (NS)					Performance Improvement Plan (PIP)			
											Primary Indicator		Companion Indicator (if applicable)	
			Denominator	Numerator	Percentage or Rate	Lower RSP	RSP	Upper RSP	NS	Performance related to NS	Baseline	Goal	Baseline	Threshold
Permanency in 12 months (entries)	12B13A	12B-15A												
Permanency in 12 months (12-23 mos)	14B15A	14B-15A												
Permanency in 12 months (24+ mos)	14B15A	14B-15A												
Re-entry to care in 12 months	12B13A	12B-15A												
Placement stability	14B15A	14B-15A												
Maltreatment in foster care	14A14B	14A, 14B, FY14	1,291,806	105	8.13	9.94	12.01	14.53	8.50	Not met	8.13	7.35		
Recurrence of maltreatment	FY13	FY13, FY14	7,226	626	8.7%	10.4%	11.2%	12.0%	9.1%	Not met	8.7%	7.9%		

Table Notes

12 month period: The 12-month period described in the denominator for this indicator (see Data Dictionary). "FY" (e.g., FY13) refers to NCANDS data which span Oct 1st - Sept 30th. All others refer to AFCARS data: 'A' refers to Oct 1st - Mar 31st; 'B' refers to Apr 1st - Sep 30th. The two digit year refers to the calendar year in which the period ends (e.g., 13A = 10/1/12 - 3/31/13; FY13 = 10/1/12 - 9/30/13).

Data Used: Refers to the initial 12-month period and the period(s) of data needed to follow the children to observe their outcome.

Observed Performance

Denominator: For Placement stability and Maltreatment in foster care - Number of days in care. For all other indicators - Number of children.
Numerator: For Placement stability - Number of moves. For Maltreatment in foster care - Number of victimizations. For all other indicators - Number of children.
Percentage or rate: For Placement stability - Moves per 1,000 days in care. For Maltreatment in foster care - Victimizations per 100,000 days in care. For all other indicators - Percentage of children experiencing the outcome.

Risk-Standardized Performance (RSP) & National Standard (NS)

RSP: Risk-standardized performance. The RSP is derived from a multi-level model and reflects the state's performance relative to states with similar children and takes into account the number of children the state served, the age distribution of these children, and, for some indicators, the state's entry rate.
Lower RSP and Upper RSP: 95% interval estimate around the RSP. Reflects the amount of uncertainty associated with the RSP. For example, the CB is 95% confident that the true value of the RSP is between the lower and upper limit of the interval.
NS: National standard. The observed performance for the nation as described in the Federal Register notice.
Performance related to NS: Indicates whether the state's 95% interval showed that the state met, did not meet, or was no different than the NS. "No Dif" means the interval includes the NS. For the permanency in 12 months indicators, "Met" is used when the entire interval is above the NS; "Not Met" is used when the entire interval is below the NS. For the remaining indicators, "Met" is used when the entire interval is below the NS; "Not Met" is used when the entire interval is above the NS. "No Dif" and "Met" do not require PIP inclusion of the indicator.

Performance Improvement Plan (PIP)

Baseline: A preliminary PIP baseline derived from the state's observed performance for the indicator using the most recent 12-month period of available data. At the time the state's PIP is due, the baseline is specified and will remain the same with the exception of certain situations when the state resubmits data for the baseline period.
Threshold: If the state must include permanency in 12 months (entries) in its PIP, the state must also not go above the threshold shown for re-entry to foster care. If the state must include re-entry to foster care in its PIP, the state must not go below the threshold shown for permanency in 12 months (entries).

CFSR Round 3 Data Profile - November 2015 - Page 2

Connecticut
CFSR 3 Data Profile

Children's Bureau
An Office of the Administration for Children & Families

November 2015
Submissions as of 08-19-15 (AFCARS) and 09-25-15 (NCANDS)

Data Quality: These checks are used when estimating state performance against the national standards and calculating PIP baselines, targets, and companion measure thresholds. Values in **bold** indicate that the percentage of problem cases exceeded the data quality limit. Blank cells indicate the check is not applicable. To determine if a data quality problem prevented estimating state performance against national standards, calculating PIP values, or both, see the table on page 1. Percentages below have been rounded for purposes of presentation. Data quality limits are applied to unrounded values.

AFCARS Data Quality Checks

MFC = Maltreatment in foster care
Perm = Permanency in 12 months for children entering care, Permanency in 12 months for children in care 12-23 months, Permanency in 12 months for children in care 24 months or more, and Re-entry to care in 12 months.
PS = Placement stability

		Limit	MFC	Perm	PS	6 month periods 10B	11A	11B	12A	12B	13A	13B	14A	14B	15A
AFCARS IDs don't match from one period to next	>	40%	✓	✓	✓	23.0	22.0	23.8	19.3	22.9	20.2	23.1	21.3	22.8	
Age at discharge greater than 21	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Age at entry is greater than 21	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Date of birth after date of entry	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Date of birth after date of exit	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dropped records	>	10%	✓	✓	✓	0.9	2.4	7.0	5.8	7.1	6.1	7.2	9.3	10.0	
Enters and exits care the same day	>	5%	✓	✓	✓	0.0	0.0	0.3	0.2	0.3	0.3	0.3	0.3	0.0	0.0
Exit date is prior to removal date	>	5%	✓	✓	✓	0.0	0.2	0.4	0.1	0.2	0.3	0.3	0.3	0.0	0.0
In foster care more than 21 yrs	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing date of birth	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing date of latest removal	>	5%	✓	✓	✓	0.0	0.0	2.6	2.3	2.6	2.3	2.9	3.1	2.4	2.5
Missing discharge reason (exit date exists)	>	5%		✓		0.6	0.9	1.3	1.7	1.6	1.7	2.2	1.4	3.9	4.7
Missing number of placement settings	>	5%			✓	0.8	0.7	3.2	4.3	3.8	4.5	4.0	2.9	5.2	6.7
Percentage of children on 1st removal	>	95%	✓	✓	✓	77.3	77.4	77.6	78.0	78.1	78.2	77.8	77.9	78.6	79.4

NCANDS Data Quality Checks

MFC = Maltreatment in foster care, RM = Recurrence of maltreatment

		Limit	MFC	RM	Fiscal Years 2011-12	2012-13	2013-14	2011	2012	2013	2014
Child IDs for victims match across years	<	1%		✓	3.9	4.0	3.9				
Child IDs for victims match across years, but DOB and sex do not match	>	5%		✓	0.3	0.5	0.7				
Missing age for victims	>	5%	✓	✓				1.1	1.1	1.1	1.0
Some victims should have AFCARS IDs in child file	<	1%	✓					100.0	100.0	100.0	100.0
Some victims with AFCARS IDs should match IDs in AFCARS files		No	✓					Yes	Yes	Yes	Yes

Section III: Assessment of Child and Family Outcomes and Performance on National Standards

Instructions

Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance on each of the seven child and family outcomes. Review the information with the statewide assessment team and determine if more recent data are available that can be used to provide an updated assessment of each outcome. If more recent data are not available, simply refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each outcome. Analyze and explain the state's performance on the national standards in the context of the outcomes.

A. Safety

Safety Outcomes 1 and 2

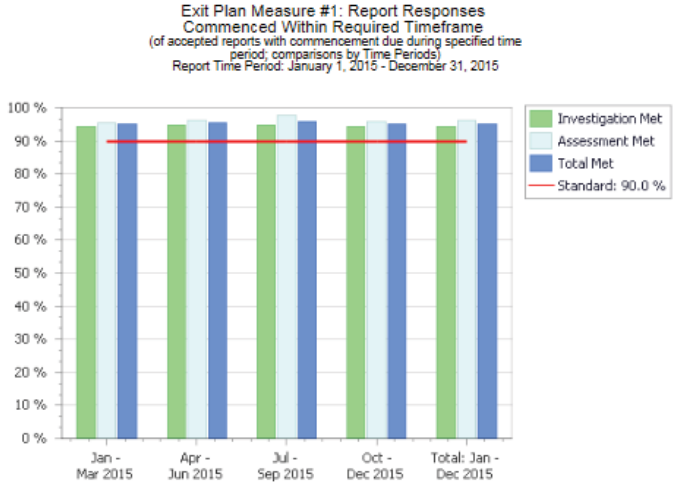
Safety outcomes include: (A) children are first and foremost, protected from abuse and neglect; and (B) children are safely maintained in their own homes whenever possible and appropriate.

- For each of the two safety outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the two federal safety indicators, relevant case record review data, and key available data from the state information system (such as data on timeliness of investigation).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Safety Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the safety indicators.

State Response:

SAFETY OUTCOME 1:

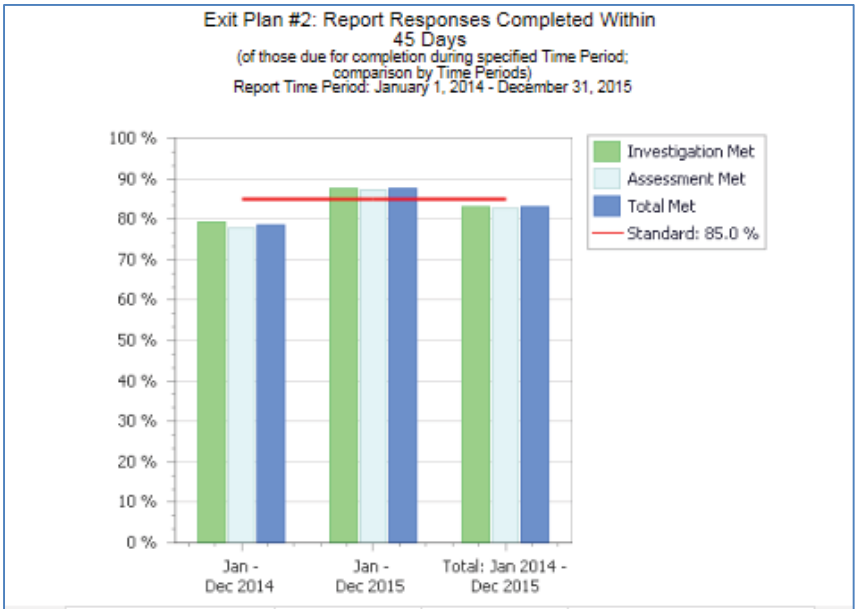
As the below data demonstrate the Connecticut Department of Children and Families (DCF/Department) has consistently commenced investigations, including those designated as Family Assessment Response (FAR) under Connecticut's Difference Response System (DRS). This is a measure that is reviewed by a Court Monitor under the Juan F. Federal Consent Decree. The Monitor's quarterly review of the Department for the period of April 1, 2015 through September 30, 2015 indicates the Department has achieved compliance of Commencement of Investigations (95.7%). In the Court Monitor's 2015 Status report, released in January 2016, is noted that "The Department has maintained compliance for at least two (2) consecutive quarters of Commencement of Investigations." This is significant as this is a basic requirement for the Court Monitor to pre-certify an outcome to support an exiting by the Department on a given measure.



Report Period	Jan - Mar 2015		Apr - Jun 2015		Jul - Sep 2015		Oct - Dec 2015		Total: Jan - Dec 2015	
- Total Investigation	3826	100.0%	4612	100.0%	4393	100.0%	4655	100.0%	17486	100.0%
Investigation Met	3616	94.5%	4365	94.6%	4164	94.8%	4387	94.2%	16532	94.5%
Investigation Not Met	210	5.5%	247	5.4%	229	5.2%	268	5.8%	954	5.5%
- Total Assessments	3353	100.0%	3320	100.0%	2668	100.0%	3122	100.0%	12463	100.0%
Assessment Met	3204	95.6%	3195	96.2%	2605	97.6%	2997	96.0%	12001	96.3%
Assessment Not Met	149	4.4%	125	3.8%	63	2.4%	125	4.0%	462	3.7%
- Total	7179	100.0%	7932	100.0%	7061	100.0%	7777	100.0%	29949	100.0%
- Total Met	6820	95.0%	7560	95.3%	6769	95.9%	7384	94.9%	28533	95.3%
- Total Not Met	359	5.0%	372	4.7%	292	4.1%	393	5.1%	1416	4.7%

The provided data to the right are the Department's achievement of Commencement of Investigations during CY 2016. This data was run in March 2016 from DCF's Results Oriented Management (ROM) system. The below are data that the Department provided in its 2015 APSR submission. These data further demonstrate that Commencement of Investigations is an area of consistent strength for the Department. Despite some staffing challenges over the past couple of years, Connecticut DCF prioritizes a timely response to ensure the safety of children and to protect them from abuse and neglect.

As noted above, the Department has faced some staffing challenges. While this has not impacted the Department's ability to commence investigations in a timely manner, these staffing challenges had effected achievement of Timely Investigations. In the Department's last APSR submission, we noted a significant declined in CY 2014, but expected that new staff hiring would improve that outcome. Based upon the January 2015-December 2015 data, this increase in staffing appears to have been successful in reversing the trend. This too is a measure that is monitored under CT's *Juan F.* federal consent decree.



Report Period	Jan - Dec 2014		Jan - Dec 2015		Total: Jan 2014 - Dec 2015	
- Total Investigation	19279	100.0%	17495	100.0%	36774	100.0%
Investigation Met	15257	79.1%	15345	87.7%	30602	83.2%
Investigation Not Met	4022	20.9%	2150	12.3%	6172	16.8%
- Total Assessments	10959	100.0%	11812	100.0%	22771	100.0%
Assessment Met	8546	78.0%	10293	87.1%	18839	82.7%
Assessment Not Met	2413	22.0%	1519	12.9%	3932	17.3%
- Total	30238	100.0%	29307	100.0%	59545	100.0%
- Total Met	23803	78.7%	25638	87.5%	49441	83.0%
- Total Not Met	6435	21.3%	3669	12.5%	10104	17.0%

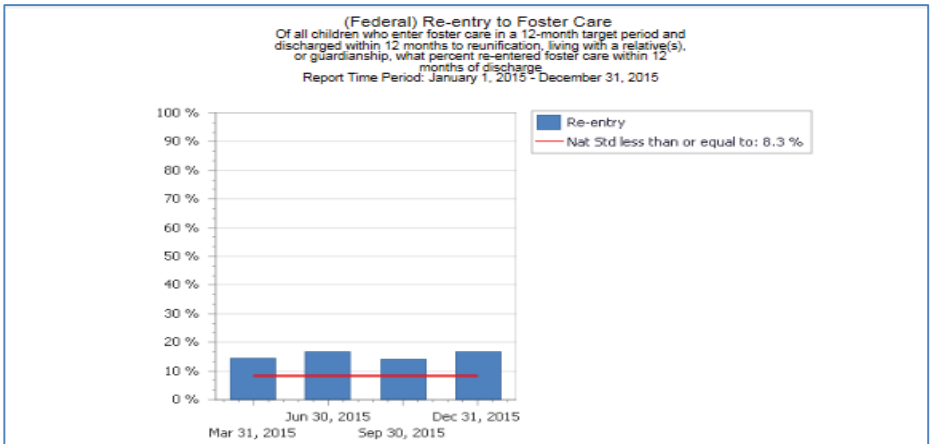
SAFETY OUTCOME 2:

ITEM 2:

Connecticut's CFSR Round 3 Data Indicators for re-entry was as follows:

CFSR ITEM	Cohort	Denom.	Number	Observed Performance	National Standard
Re-Entry in 12 Months	Ch. Enter care in a 12 month period + exiting within 12 months	403	41	10.2%	8.30%

A review of this measure for the report period of January 1, 2015 – December 31, 2015, pulled from ROM, suggests that this items has not improved. The ROM data indicates that the cohort are children who entered care starting April 2012 forward. While further analysis (e.g., statistical modeling and a controlled case review of a statistically significant sample) is likely needed to more conclusively determine why this measure continues to be below the national standard, these entry period (i.e., April 2012) coincides with the Department's statewide launch of a Differential Response System (DRS). Connecticut began DRS in March 2012. The cohort for these ROM data are after the start of DRS. CT DCF's removal rate has also decreased, so there are fewer children coming into care. Fewer children entering care makes the denominator in the re-entry measure smaller and makes the percentage higher.



Report Period End	Mar 31, 2015		Jun 30, 2015		Sep 30, 2015		Dec 31, 2015	
- Total	488	100.0%	478	100.0%	436	100.0%	459	100.0%
Maintained Permanency	417	85.5%	399	83.5%	375	86.0%	383	83.4%
- Re-entry	71	14.5%	79	16.5%	61	14.0%	76	16.6%
Entered Care During	Apr 2012 - Mar 2013		Jul 2012 - Jun 2013		Oct 2012 - Sep 2013		Jan - Dec 2013	

Next, beginning in 2011, the Department has been prioritizing placements with relatives and kin, including through guardianship. Further, during this same period the Department was significantly reducing the number of youth in congregate care, especially out of state. Certainly not dispositive, but these factors in concert may be impacting the profile of the children and families who the Department serves. In particular, the youth may be more complex than previous cohorts, and their families/kin to whom they are returning may require an increased level of support in order to maintain permanency. The efforts to increase placements with kin, including fictive, may also be a factor. While the

Department has a payment mechanism for placements with fictive kin under a foster care construct, it was only during the 2015 legislative session was the Department able to get a bill passed that extended subsidized guardianship to fictive kin. Also, the Department has increased funding for community-based supports within the last year. For example, community-based spending in State Fiscal Year (SFY) 2011 was a little over $318 million. In SFY 2015, this same spending was just under $367 million. This increase has allowed for development and/or expansion of services including, but not limited to:

- Differential Response - $5,250,000
- ACCESS-Mental Health - $1,810,000
- MATCH-ADTC - $1,000,000
- TFCBT – Bridgeport Public Schools - $500,000
- TFCBT – South-central Public Schools - $1,000,000
- Trauma Focused CBT - $1,000,000
- Intensive Home Based Services: Family-Based Recovery - $1,217,546
- Emergency Mobile Psychiatric Services enhancement - $110,282
- MST – Building Stronger Families - $1,584,620
- MST – Problem Sexual Behaviors - $277,104
- Care Management Entity - $821,918

It should be noted that ACCESS Mental Health CT is a program that offers free, timely consultative services for pediatricians seeking assistance in providing behavioral health care to children and adolescents under the age of 19 years, irrespective of insurance. The Care Management Entity (CME) was created to assist children with complex needs and their families, as they often are involved with multiple providers and systems, or are at very high risk for such involvement. Therefore, youth and families end up with multiple plans of care and multiple care coordinators. The CME is responsible for developing and implementing comprehensive individualized plans of care with each participating youth and his or her family. ACCESS Mental Health CT and the CME are examples of investment by the Department in services that are available to children and families in the community to support permanency and the provision of care in the least restrictive settings possible.

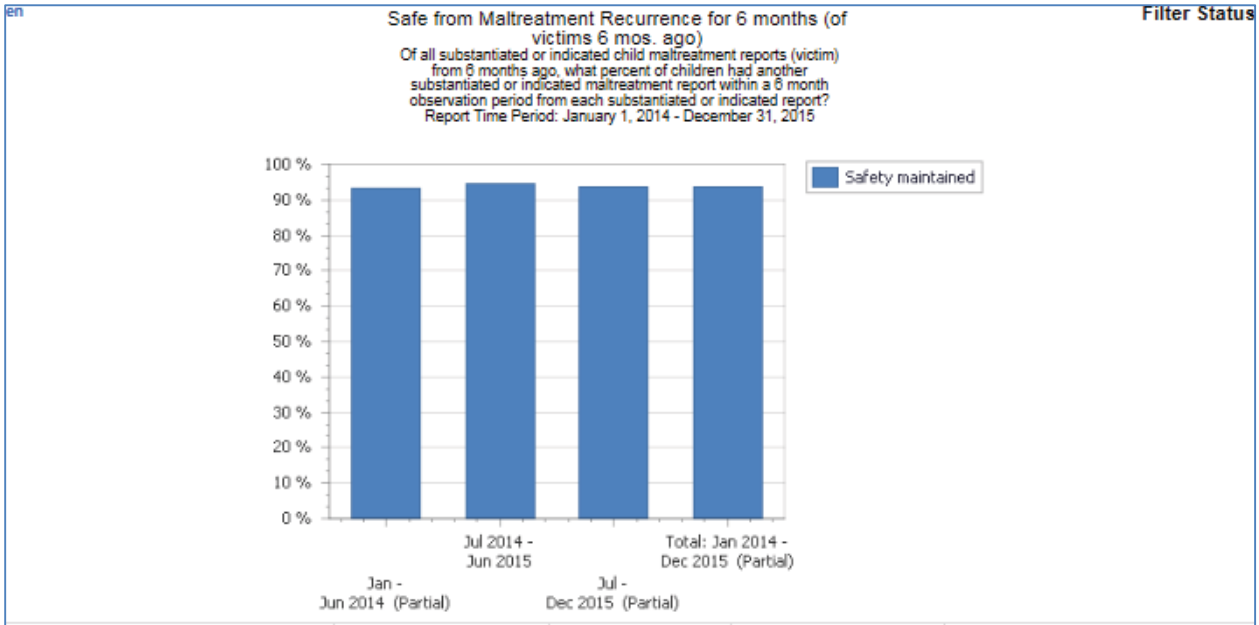
Furthermore, this is increase in community-based spending is even more amplified by the fact that the current number of children in placement (N= 4,109) is significantly smaller than was in 2011 (N=4,780). The Department will need to continue to monitor this measure and explore the potential factors that may be impacting outcomes. Similarly, we will have to assess whether some of the additional supports through increased community-spending, especially for school-base behavioral health services, ACCESS Mental Health CT and the Care Management Entity, and the availability of subsidies for fictive guardianships are aiding with turning the curve regarding this measure.

Next, the CFSR Round 3 Data Indicators for Recurrence of Maltreatment indicates that CT's observed performance exceeds the national standard.

CFSR ITEM	Cohort	Denom.	Number	Observed Performance	National Standard
Recurrence of Maltreatment	Victims of a substantiated maltreatment report in a 12 month period	7931	546	6.9%	9.00%

A review of ROM data for the report period of January 2015 – December 2015, indicates that while the observed performance has declined, the Department continues to meet the national standard.

Safe	6719	91.2%
Recurrence	645	8.8%
Total Child Victims	7364	100.0%
Inital maltreatment during	**Jan - Dec 2014**	



Report Period	Jan - Jun 2014 (Partial)		Jul 2014 - Jun 2015		Jul - Dec 2015 (Partial)		Total: Jan 2014 - Dec 2015 (Partial)	
- Total sub/indicated report 6 mos. ago	3840	100.0%	7745	100.0%	3770	100.0%	15355	100.0%
Safety maintained	3580	93.2%	7311	94.4%	3528	93.6%	14419	93.9%

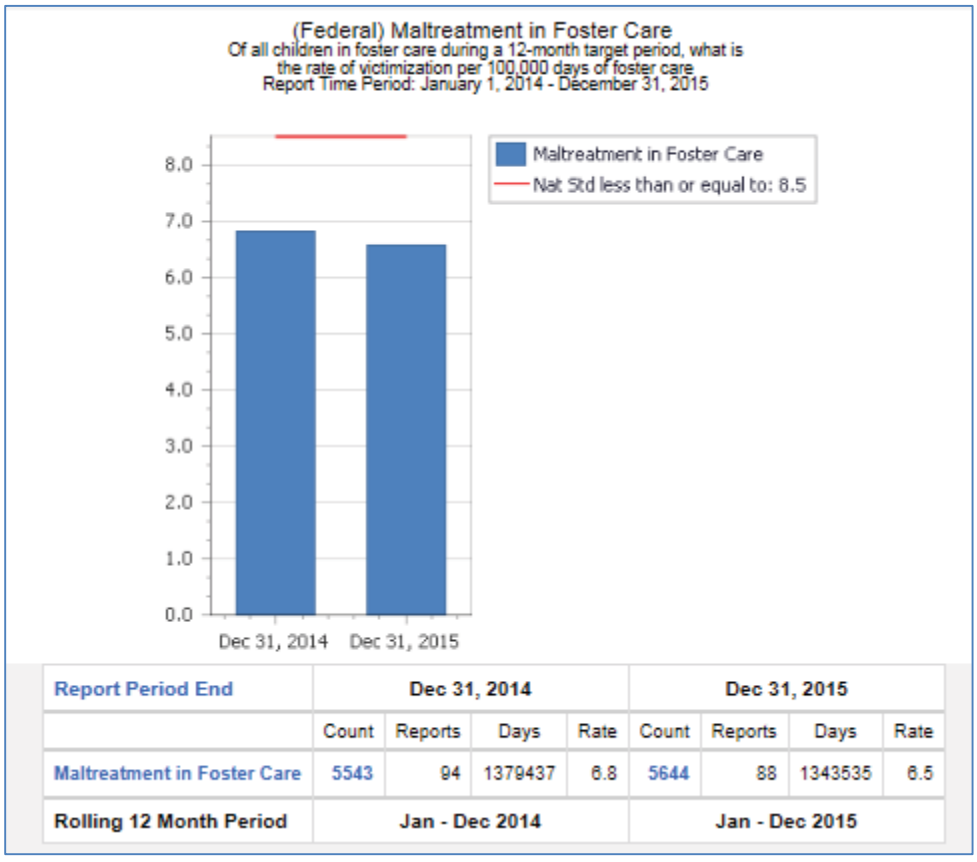
Data from ROM regarding children being safe from maltreatment recurrence for 6 months reveals that the Department is doing well regarding this measure.

Some of the challenges noted with respect to the reentry indicator (e.g., complexity of cases) may also be impacting the 12 month Recurrence of Maltreatment measure. Similarly, some of the service system investments may have a positive effect on this indicator. Thus, the Department will continue to monitor this measure.

The Department has achieved the national standard with respect to the Maltreatment in Foster Care indicator as evidenced by the CFSR data.

CFSR ITEM	Cohort	Served	Denom.	Number	Observed Performance	National Standard
Maltreatment in FC	Ch. In FC during a 12 month period	5321	1401753	105	7.49	8.04

CY 2015 Data from CT's ROM system suggests that the Department continues to exceed the national standard for this indicator.



Report Period End	Dec 31, 2014				Dec 31, 2015			
	Count	Reports	Days	Rate	Count	Reports	Days	Rate
Maltreatment in Foster Care	5543	94	1379437	6.8	5644	88	1343535	6.5
Rolling 12 Month Period	Jan - Dec 2014				Jan - Dec 2015			

ITEM 3:

Finally, the Department engages in a comprehensive Administrative Case Review process (ACR). Last year, 13,700 ACR meetings were held. This case review work is done by Social Work Supervisors who are DCF Central Office employees assigned to the regions. Using the 38 page ACR instrument (ACRi), the Department reviews risk and safety for all cases that undergo the ACR. As the below data indicate, concerted efforts to assesses and address risk and safety of children in placement was routinely assessed as a strength at the rate of equal or greater than 90%.

Measure	Statewide			
	Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015
	Strength	Strength	Strength	Strength
	%	%	%	%
Risk & Safety - Child in Placement	93%	92%	90%	91%

In addition, ACR staff evaluate the timeliness and accuracy of the use of the Structured Decision Making (SDM) tool. SDM is a tool that supports the evaluation of safety and risk for children who present to a protective services agency. ACRi data for CY 2015 suggest that DCF staff do well with completing the SDM in a timely and accurate manner with respect to assessing the child. The same data with respect to the parent suggests that this is an area in which some improvement could occur.

Measure	Statewide			
	Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015
	Strength	Strength	Strength	Strength
	%	%	%	%
Timely Accurate SDM - Parents	79%	77%	75%	76%
Timely Accurate SDM - Child	87%	87%	79%	83%

The Department convened a workgroup during 2015 to determine if there was another tool that the Department might consider using instead of SDM. After an extensive reviews, it was determined that SDM remained the best option. The Department has engaged the developers of SDM, including having them come on site this past fall. CT DCF will be working with them to enhance our use of SDM, including creating a robust quality assurance mechanism to more empirically monitor the efficacious execution and use of the SDM tools. This initiative regarding SDM should positively impact the rate of accuracy for both the parent and child assessments.

B. Permanency

Permanency Outcomes 1 and 2

Permanency outcomes include: (A) children have permanency and stability in their living situations; and (B) the continuity of family relationships is preserved for children.

- For each of the two permanency outcomes, include the most recent available data demonstrating the state's performance. Data must include state performance on the four federal permanency indicators and relevant available case record review data.
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Permanency Outcomes 1 and 2, including an analysis of the state's performance on the national standards for the permanency indicators.

State Response:

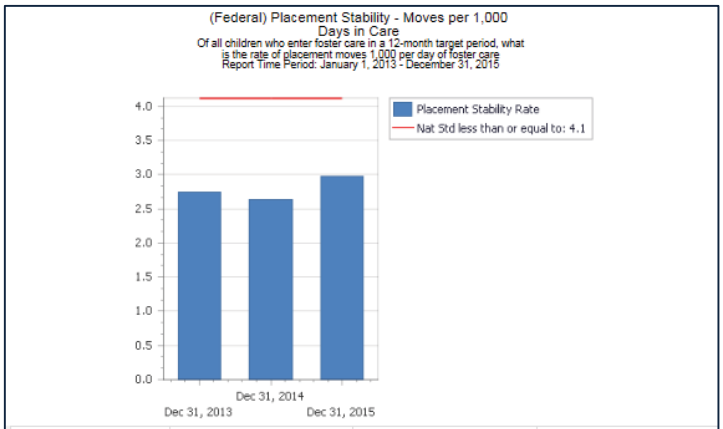
Permanency Outcome 1

Item 4:

CT's CFSR Round 3 Data Indicators information is below. As these data notes, the Department's observed performance was within the national standard.

CFSR ITEM	Cohort	Entries	Denom.	Number	Observed Performance	National Standard
Placement Stability	Ch. Entering foster care in a 12 month period	1861	315865	877	2.78	4.12

A review of this item using CT's ROM system data for CY 2015 indicates that the State's performance continues to meet the national standard:

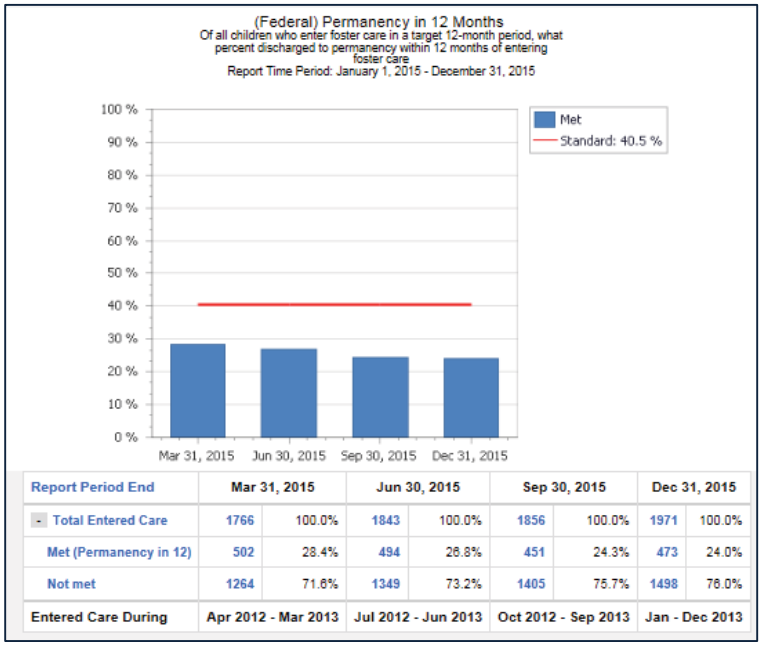


Report Period End	Dec 31, 2013				Dec 31, 2014				Dec 31, 2015			
	Count	Moves	Days	Rate	Count	Moves	Days	Rate	Count	Moves	Days	Rate
Placement Stability Rate	1991	868	315909	2.7	1872	841	320013	2.6	1920	924	310980	3.0
Rolling 12 Month Period	Jan - Dec 2013				Jan - Dec 2014				Jan - Dec 2015			

Connecticut's other Permanency Outcomes as per the CFSR Round 3 Data Indicators are as follows:

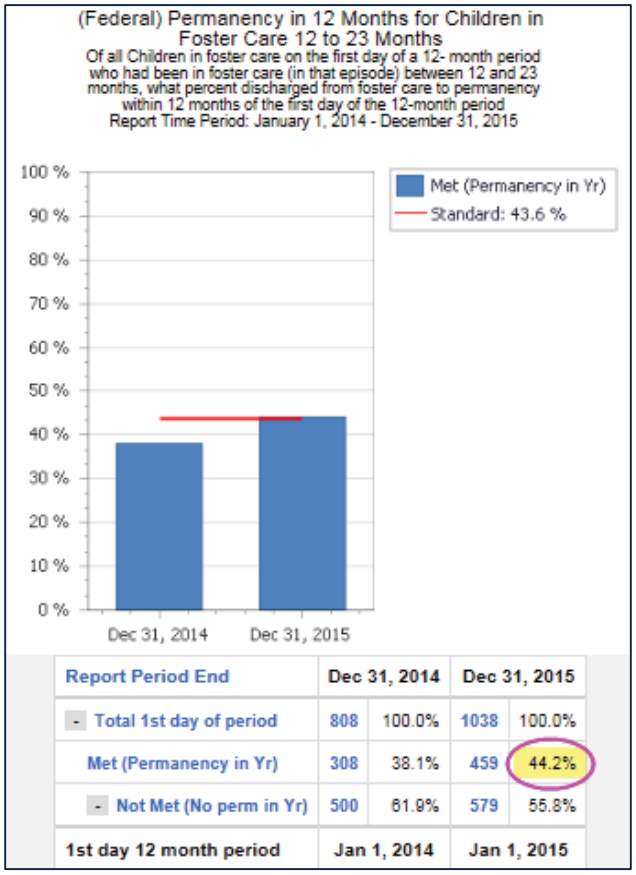
CFSR ITEM	Cohort	Demon	Number	Observed Performance	National Standard
Perm. in 12 Months	Ch. Entering Care in 12 month period	1996	419	21.3%	40.40%
Perm. in 12 Months	Ch. In care 12-23 months as of 1st day of 12 month period	864	264	28.9%	43.70%
Perm. in 12 Months	Ch. in Care 24 or > as of the 1st day of a 12 month period	1243	236	19.0%	30.30%

Data from CT's ROM system for CY 2015 are as follows:

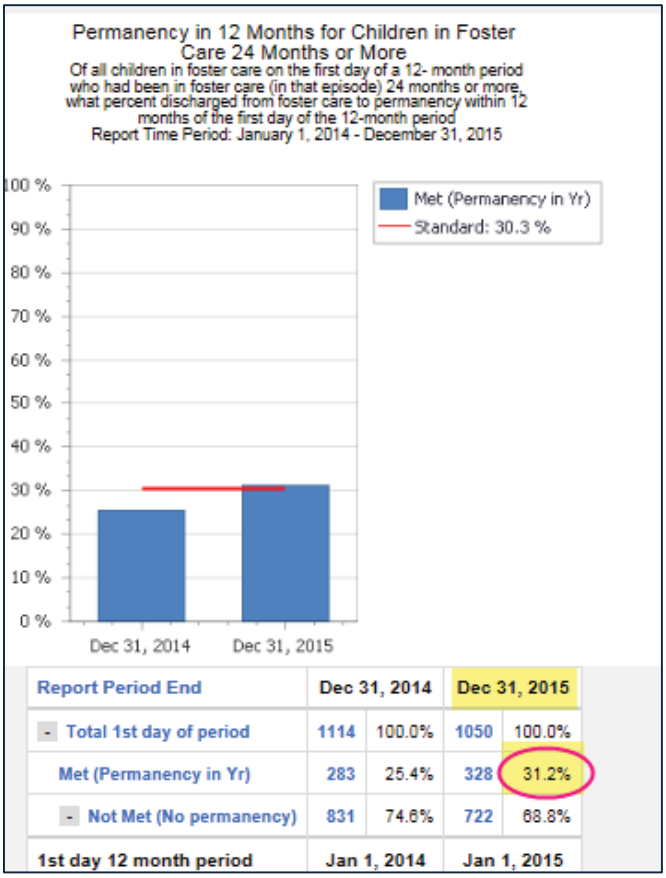


Report Period End	Mar 31, 2015		Jun 30, 2015		Sep 30, 2015		Dec 31, 2015	
- Total Entered Care	1766	100.0%	1843	100.0%	1856	100.0%	1971	100.0%
Met (Permanency in 12)	502	28.4%	494	26.8%	451	24.3%	473	24.0%
Not met	1264	71.6%	1349	73.2%	1405	75.7%	1498	76.0%
Entered Care During	Apr 2012 - Mar 2013		Jul 2012 - Jun 2013		Oct 2012 - Sep 2013		Jan - Dec 2013	

As the above data indicate, Connecticut has made progress on this indicator, but still has not achieved the national standard for permanency for children entering care in a 12 month period. The Department appears to be meeting the national standard for the other two CFSR Permanency Items (see below). The Department has been prioritizing relative placements, gotten legislation passed to allow for subsidized guardianship for fictive kin, utilizes Permanency Teaming, targeted recruitment, Wendy's Wonderful Kids, and a process termed Considered Removal-Child and Family Team Meeting (CR-CFTM). Some of the progress may specifically be due to the implementation CR-CFTM.



Report Period End	Dec 31, 2014		Dec 31, 2015	
- Total 1st day of period	808	100.0%	1038	100.0%
Met (Permanency in Yr)	308	38.1%	459	44.2%
- Not Met (No perm in Yr)	500	61.9%	579	55.8%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015	



Report Period End	Dec 31, 2014		Dec 31, 2015	
- Total 1st day of period	1114	100.0%	1050	100.0%
Met (Permanency in Yr)	283	25.4%	328	31.2%
- Not Met (No permanency)	831	74.6%	722	68.8%
1st day 12 month period	Jan 1, 2014		Jan 1, 2015	

CR-CFTM is required when the Department is contemplating an out of home placement for a child. It was implemented in February 2013. The purpose of a CR-CFTM is to mitigate safety factors in order to prevent removal from the home by identifying and utilizing the family's natural or formal supports in safety planning. The meeting results in a live decision about safety/removal and recommendations regarding placement.

	2014	2015*
Child Specific Meetings	2611	1928
Meetings Held Prior	1862 (71%)	1503 (78%)
# Children who Entered Care	939 (50.4%)	685 (45.6%)
# Children – No Entry	923	818
# Children who Entered Care w/in 60 days	713 (38.3%)	587 (39.1%)
Of the entries, # children placed with relatives/kin	441 (47%)	384 (56.1%)

This chart represents the total number of child specific meetings for 2014 and the first 3 quarters of 2015 (through 9/19/15).

While CR-CFTM may be one strategy assisting with closing CT's gap with the national standard regarding the Children Entering Care in a 12 month period indicator, it may also further evidence the fact that over the past 3-4 years the DCF caseload has become increasing more complex. Implementation of DRS and even CR-CFTM are persuasive that the Department has been able to divert entry where risk and safety are lower. Therefore, more high risk and cases with safety issues that can't be readily mitigated are coming into care. This might suggest that the complexity of these cases might extend the timeframe by which permanency is achieved. This might be further supported by the fact that the Department's CY 2015 data for achievement of permanency for Children in care 12-23 months as of 1st day of 12 month period and that for Children in Care 24 or > as of the 1st day of a 12 month period has significantly improved. In fact, CT's CY 2015 observed performance for these measures appears to suggest that the State is meeting the national standard.

ITEM 5:

Data the ACRi and the *Juan F.* Plaintiff's Monthly Report suggest that Connecticut is planning for children's permanency and establishing permanency goals and making efforts to achieve reunification, guardianship, adoption or other planned permanent living arrangement for child. In particular, data from the ACRi[1] indicates that planning for permanency is routinely rated as a strength. In addition, data from the Plaintiff's Monthly report (below), which is based on the number of children under 18 in placement as of March 23, 2016, indicates that 90% of all children in placement have an established permanency/case plan goal. Furthermore, over 92% of those cases without a goal have been in care less than 60 days.

ACR Data: 1/1/15-4/31/15	State	
	Total	Strength
	#	%
Planning for Permanency	4,627	94%

XII. Pre-TPR Children In Care by Permanency Goal, Status of TPR Filing and Time In Care (Mos)

TPR Status	PRE-TPR
Age_Grp2	<18 years old

Case Plan Goal	TPR Filed?	Time In Care								
		<2	>=2<6	>=6<15	>=15<22	>=22<36	>=36<48	>=48<60	>=60	TOTAL
	NO	1		5		1				7
	TOTAL	1		5		1				7
	YES			2					1	3
	NO	1	5	68	17	15	3	2	1	112
	TOTAL	1	5	70	17	15	3	2	2	115
	YES					1				1
	NO		4	11	2	6	1		4	28
	TOTAL		4	11	2	7	1		4	29
	NO		1	1			1			3
	TOTAL		1	1			1			3
(Blank)	YES	6	1							7
	NO	261	13	5		2			1	282
	TOTAL	267	14	5		2			1	289
Adoption	YES	4	10	34	72	64	9	4	7	204
	NO	2	10	187	89	66	11	2	4	371
	TOTAL	6	20	221	161	130	20	6	11	575
APPLA	YES				1	3	3		13	20
	NO	1	4	11	14	32	24	24	24	134
	TOTAL	1	4	11	15	35	27	24	37	154
LTFC Relative	NO			1		11	2	2	2	18
	TOTAL			1		11	2	2	2	18
Reunification	YES		4	5	2	4	3	1	5	28
	NO	76	483	590	153	77	15	7	9	1,410
	TOTAL	76	487	595	155	81	18	8	14	1,438
TOG:Non-Sub	NO		1	8	1	2	2	1		15
	TOTAL		1	8	1	2	2	1		15
TOG: Sub	YES				3	7	2		6	18
	NO			52	80	60	20	6	8	226
	TOTAL			52	83	67	22	6	14	244
TOTAL		352	536	984	434	351	96	43	85	2,887

[1] This particular variable continues to be reviewed by ACR staff, but since May 1, 2015, it is not parsed out separately in the ACR reports. Thus, the presented data is for the period of January 1, 2015 – April 31, 2015. Data for CY 2014 indicates this item is rated as a strength at the level of 96% (N= 11,043). Thus, it would appear that planning for permanency has consistently been rated as a strength through the ACR process.

ITEM 6:

ACR data for CY 2015 suggests that DCF staff are making concerted efforts to achieve permanency for children at a high level:

Measure	Statewide			
	Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015
	Strength	Strength	Strength	Strength
	%	%	%	%
Permanency	93%	92%	91%	91%

Data from the Judicial Branch provides some context regarding the number of Permanency Plans that the Court has approved, including those for OPPLA/APPLA:

Explanation: The chart displays the total number of permanency plans approved and also displays the number of those approved that had APPLA/OPPLA goals that were approved by the court during calendar year. Based on a code that is entered, the type of permanency plan goal can be determined.

Cohort: Permanency Plans that were approved during CY15.

APPLA/OPPLA Plans for CY15	
Total Number Of Permanency Plans Approved	3459
Number of APPLA/OPPLA Plans Approved	541
Number of Independent Living Program Approved	93
Number of Long Term Foster Care Approved	152
Number of Other Approved	12

Time to Permanency

The below are data from the CT Judicial Branch. This table is the time to permanent placement. This is determined by the number of days from the date of removal to the date the child court case being closed by reunification, transfer of guardianship or adoption. Both the median and the average number of days to permanent placement have been calculated. The cohort is children who exited care by adoption, transfer of guardianship or reunification during FY15:

FY14/15									
	#	# Within 12 months	# Within 18 months	# Within 24 months	Average	Median	% Within 12 months	% Within 18 months	% Within 24 months
Adoption	504	12	53	148	1090	903	2.4%	10.5%	29.4%
Transfer of Guardianship	121	42	89	94	493	455	34.7%	73.6%	77.7%
Reunification	534	359	432	471	362	257	67.2%	80.9%	88.2%

Reunification:
As the above data suggest, permanency of children within 12 months is an area that may not be at its maximal level. Review of DCF data indicates that 12 month reunification has declined since 2012. As has been indicated with respect to other CFSR items, CT DCF thinks some of the measures are impacted by the introduction of DRS, which began in the 1st Quarter of CY 2012. Some of the decline may be attributable to the types of more complex and multi-system involved cases that are now being opened under the traditional CPS track. Moreover, the use of CR-CFTM at the onset of the contemplation of a removal, may also be amplifying the presented lower attainment levels. For example, as the early CR-CFTM data reveals, for CY 2014 and CY 2015, 1471 children were diverted from DCF placement. This fact, coupled with the inherently more complex cases that are being opened since the emergence of DRS, may suggest that the cases in which a child must enter care have more elevated challenges and needs than in previous years; especially before 2012. Thus, reunification within 12 months, may be more difficult. Finally, it should be noted that the denominator over the course of the past several years has been consistently declining. That small "N" does also introduce more noise into the attainment percentages as smaller changes in either direction are more impactful on the presented outcome.

Timely Adoption:

Data from CT's ROM system indicate that timely adoption has dipped beginning 2011 (41% met in 2010, 39% in 2011 to 26% in 2014). This decline may be attributed to the focus on relative/kinship placements. Since 2011, the number of out of home placements that were with relatives increased from 21% to the current level of 41%. The Department offers very robust services and supports for families caring for children who are placed out of home. Connecticut also allows youth to remain in foster care until age 23. The Department pays for the college of youth in foster care until they age out. Anecdotally, we have been informed that some relatives are reluctant to adopt given CT's generous benefits that are tied to fostering a youth until early adulthood. Thus, for some kin, adoption may not be viewed by as a viable option, especially if they think that there are supports that they need and fear they might lose by adopting. The Department must do a better job to communicate and educate relative families as to the support, services and benefits that are and can be provided through adoption.

Guardianship

ROM data

	2008		2009		2010		2011		2012		2013		2014		2015	
Report Period	2008		2009		2010		2011		2012		2013		2014		2015	
Met	185	70.3%	167	77.3%	139	79.0%	150	84.3%	137	79.7%	129	69.4%	105	65.2%	147	70.3%
Not Met	78	29.7%	49	22.7%	37	21.0%	28	15.7%	35	20.3%	57	30.6%	56	34.8%	62	29.7%
Total	263	100%	216	100%	176	100%	178	100%	172	100%	186	100%	161	100%	209	100%

Juan F. data

Q3 2015	Q2 2015	Q1 2015	Q4 2014	Q3 2014	Q2 2014
75.7%	66.7%	77.8%	72.5%	73.2%	65.2%

While the guardianship achievement levels have decreased over the past couple of years, the 2015 data may be reflective of a possible trend reversal. Last year, CT legislation was passed expanding guardianship opportunities. In particular, the legislation now makes fictive kin caregivers eligible for guardianship subsidies, and allows for the transfer of such subsidies from one caregiver to a successor caregiver. CT had noted in its 2015 APSR submission that this new legislation might add in increasing the number of guardianship placements.

Permanency Outcome 2:

DCF has conducted three pilots to prepare for the CFSR. Some of the available data from the last pilot has been included to show how CT appears to be faring on various items. The overall rating for Permanency Outcome 2, based on the last pilot (N= 14), is as 93% Substantially Achieved and 7% Partially Achieved. While this a small sample size, the results are promising. It should be noted, that 36 total cases were reviewed for the last pilot, but only 14 have undergone the full CT CFSR secondary QA process. Therefore, we are only including the results for the cases that have completed the entire CT CFSR QA process.

ITEM 7:

As noted, the Department has increased kin placement from 21% in January 2011 to 41% as of March 1. 2016. This lens is thought to be assisting the Department is better ensuring that siblings in foster care are placed together unless separation was necessary to meet the needs of one of the siblings. The CT Court Monitor's quarterly review of the Department for the period of April 1, 2015 through September 30, 2015 indicates the Department has achieved compliance with Sibling Placement (92.0%). This measure's stand is similar to the CFSR Item 7 construction with respect to attainment being articulated as requiring siblings to be placed together unless there are documented therapeutic reasons for separate placements. It should also be noted that this measure was pre-certified[2] by the Court Monitor as of April 2015. Thus, the Department has demonstrated consistent achievement of this measure.

ITEM 8:

Connecticut has been piloting the Round 3 CFSR tool and the CFSR process. Data from this pilot rates this Item as a strength at the level of 91%. While the sample size was small (N= 14), these results are encouraging given a recent study the Department conducted regarding sibling and parent visitation. The details of that study are below. The results from that review were not as strong as those from the pilot. The DCF visitation study was conducted strictly from a review of available LINK data and case record narratives. The CT DCF CFSR Pilot process, on the other hand, included interviews of DCF social workers, children/youth, parents and providers. Therefore, these pilot data may be more reflective of the true level of visitation that is occurring.

In October 1, 2014, Section 17a-10a of Public Act 12-671 of the Connecticut General Statutes was amended, and affirms the need for child and parent visitation. The Act established a requirement that all children in the care and custody of the Commissioner of the Department of Children and Families (DCF) under an Order of Temporary Custody or Commitment, and who have been separated from their parents or siblings as a result of intervention by the Commissioner, and who are placed within fifty miles of one another in Connecticut, be afforded visitation with their siblings and parents. The law states that visitation with siblings for children placed in the care and custody of the commissioner of DCF should occur no less than once per week, unless it is not in the best interest of the child. The required standard for parental visitation is "as frequently as reasonably possible" based upon consideration of the best interests of the

[2] *If DCF has sustained compliance as required by the Revised Exit Plan for at least two consecutive quarters (6 months) for any Outcome Measure ("OM"), the Court Monitor may, in his discretion, conduct a "pre-certification review" of that OM ("Pre-Certification Review"). The purpose of the Pre-Certification Review is to recognize DCF's sustained improved performance, to identify and provide a prompt and timely opportunity to remedy any problem areas that are affecting the well-being of* Juan F. *class members, and to increase the efficiency of DCF's eventual complete compliance and exit from the Consent Decree.*

separated child and "shall be sufficient in number and duration to ensure continuation of the relationship," unless otherwise ordered by the court.

This past October, The DCF Office for Research and Evaluation, in collaboration with Regional Quality Improvement managers and other qualified reviewers, conducted a study of 154 target children who were under the care and custody of the Commissioner of DCF at some point between October 1, 2014 and June 30, 2015. Each child's visitation with their parents, and each of their identified siblings were evaluated. Compliance with the statute was operationalized at the target child and sibling level, resulting in measurement for 278 sibling pairs and 154 children with their parents.

The Sibling Visitation Study results are as follows**:**

Siblings:
The study included 154 unique children, which yielded 278 sibling pairs. Of the 278 sibling pairs, the frequency of visitation met or exceeded the expectation for 115 (41.4%) of the sibling pairs. The expectation was met for 76 (49.4%) target children and at least some of their siblings. Documentation relating to the factors considered in making visitation determinations was located in the child's plan of treatment, which the Department refers to as the "Case Plan," for 159 (57.2%) pairs. For 67 (24.1%) of the pairs, the information was located within supervisory conference notes, in case narratives or were obtained directly from the assigned social worker or supervisor. For the 49 pairs in which the expected frequency determined by the department was less than weekly, there was documentation supporting the determination for 15 (30.6%) of the sibling pairs and for 14 (41.2%) of the target children

There were a number of identified barriers to meeting the visitation expectations. The most often identified barrier for the sibling pairs for whom DCF did not meet the visitation expectation was "Parent Refusal/Unavailable" (26, 16.0%). This consisted of cases in which the parents of the siblings of the target children either refused to allow visitation or did not attend scheduled visits that included the siblings. This was followed by "Child Refusal" to visit (24, 14.7%). This included cases in which either the target child or the sibling refused to visit. For the majority of the pairs, the "Other" barrier was chosen. The majority of these responses consisted of cases in which the visitation was allowed to be scheduled and facilitated by the caretakers, which included foster parents, guardians, adoptive parents, etc. In some instances, there were references in the documentation that visits occurred, but because they are being facilitated by someone other than DCF direct service staff, there isn't information about the dates, duration or assessments of these visits. Similar information is lacking in cases in which the target child is an adolescent and visiting with adult siblings. In the absence of any known safety concerns, such youth are often encouraged to manage scheduling their own visits in an effort to ensure a normative experience for them, but it is more difficult to obtain comprehensive and accurate reporting on results from them.

In addition to the barriers identified in the study, reviewers reported observations made during their case reviews that inform case practice, as well as limitations in the data collection. This includes the documentation regarding whether the interactions between siblings is incomplete or absent. In some instances, there is contradictory information within the case record. For example, a case plan might indicate that visitation is occurring at a given frequency, but the information in the narratives does not support that frequency. Also, caretakers, including adoptive parents or those to whom guardianship has been granted, sometimes refuse to allow the child to have contact with his/her family.

These observations are being further assessed to determine how the presented issues might be ameliorated to support increased visitation.

Parents:
The compliance determination for visitation with parents was based on 123 children of the 154 children who populated the sample. This yielded 213 unique child/parent pairs. Thirty-one of the children were not included in the measure because they did not have any parents for whom visitation would have been expected during the period under review. The expected frequency of visitation was met for 109 (51.2%) parent/child pairs. In cases in which there was an expected frequency determined by the department, the compliance was based on whether or not the typical pattern of the visitation exceeded or met that expectation. For cases in which an expectation had not been determined and/or documented, the compliance was based on the reviewer's determination concerning whether or not the typical pattern and quality of visitation were sufficient to ensure the continuation of the relationship.

Reviewers attempted to identify barriers to meeting visitation for the 104 (48.8%) parent/child pairs for which the measure was not met. The most often identified barrier was "Parent Refusal/Unavailable", which was identified for 53 (51.0%) of the pairs. This was followed by "Other" for 17 (16.3%) of the pairs. The "Other" category included parent incarceration, parent illness, or parent's transiency. For 14 (13.5%) of the pairs there wasn't documentation regarding a barrier to visitation.

There was a clear visitation expectation identified for 170 child/parent pairs. There was documentation found in the Case Plan regarding the frequency for 139 (81.8%) of these pairs. For the remaining cases, visitation documentation was located in the running narratives.

Based upon the study, the Department identified some recommendations. For example, additional training and guidance regarding documentation would assist in presenting an accurate representation of the work that is being done to promote, support and facilitate ongoing relationships between children in care and their families. Visitation contacts is one of the areas the Department will be enhancing in the new child welfare case management and reporting system (SACWIS/CCWIS). It is expected that this will better enable the Department to track and quantify visitation.
The specific recommendations are:

1. Ensure that staff are aware of the visitation expectations and have an understanding of the importance of visitation for children in care with their families by having managers and supervisors cover this area during supervision;
2. Provide additional guidance for staff on documenting the visitation plan, factors used in determining visitation frequency, and barriers to visitation;

3. Establish a standard protocol for obtaining and documenting information from visitation programs;

4. Establish a standard protocol for obtaining information from relatives and foster parents who are facilitating visits;

5. Establish a standard protocol for obtaining information from youth when they facilitate their own visits or have unsupervised visitation especially with adult siblings;

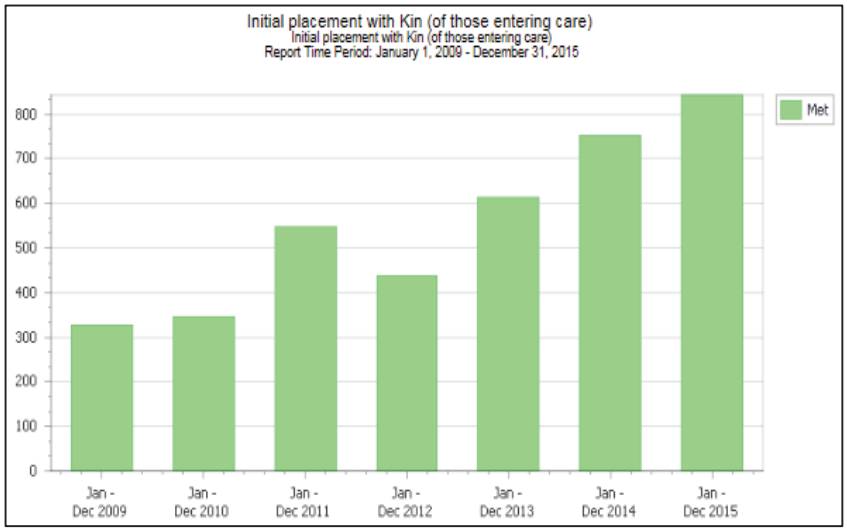
6. Establish guidelines for consulting with DCF Area Resource Group and other clinicians when children are refusing to visit with family members to help explore and address the barriers;

7. Develop strategies to assist with sibling contact once a child is adopted or guardianship is transferred; and

8. Develop a practice guide and update current policy concerning child visitation with parents and siblings.

ITEM 9

Connecticut has been piloting the new CFSR tool in order to prepare for its self-directed review. While a small sample (N= 14[3]) the data for Preserving Connections indicates that 85%[4] (N=11) of the cases were rated as a strength for this item.



ITEM 10

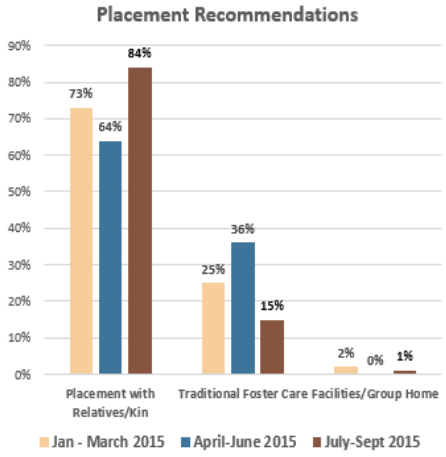
As has been noted in other section of this self-assessment, the Department achievement of placing children with relatives prior to 2011 was considerable low. At the start of CY 2011, only 21% of children were placed with relatives. Initial placements with relatives was 17.4%.

The Department has set up annual Performance Expectation across the agency. Each Region, Facility and Team within DCF are to develop operational strategies to demonstrate their outcomes and progress achieving each performance expectation and what they will be employing to support and/or maintain attainment. The agency has established a goal of a minimum of 30% of children in placement residing with a relative and 40% of initial placements are to be with relatives. LINK data from the Children in Placement dashboard indicates that as of March 1, 2016, over 41% of children in care are placed with a relative. This and last month's data indicate that initial placement with relatives have been 37% and 39%, respectively. The below table demonstrates the Department's continuing progress to increasingly place children initially with relatives.

The Considered Removal- Child and Family Team Meeting data further evidences the efforts that the Department has been making to divert children from placement when safe and possible, or to initially place with a relative if in-care placement cannot be adverted.

[3] 36 total cases have been reviewed during the last CFSR pilot, but only 26 of those cases that have finished going through the first and secondary QA. These data represent the 14 out-home cases out of the 26 (12 were in-home cases) that have gone the CT's full CFSR QA process.

[4] 1 case was N/A for this item



This chart represents CR-CFTM documented in LINK since January 2015. Data includes CR-CFTM held prior to removal only. If meetings are held prior to the child's removal, children are more likely to be placed with relatives/kin.

For this most recent quarter, the percentage of children placed with relatives/kin increased to 84% while the children placed in traditional foster care settings decreased to 15%. Two children were recommended for higher levels of care in this past quarter.

ITEM 11:

The preservation of children's connections is an area reviewed through CT's ACR process. CY 2015 ACR data for the continuity of relationships measure suggest that this is general area of strength for the Department. It is defined as DCF having made concerted efforts to maintain the out-of-home child's relationship with their parents, father and mother. Furthermore, data from CT's CFSR pilot indicates that Item 11 was rated as a 100% strength (N=10[5])

Measure	Statewide			
	Quarter 1, 2015	Quarter 2, 2015	Quarter 3, 2015	Quarter 4, 2015
	Strength	Strength	Strength	Strength
	%	%	%	%
Continuity of Relationship - Child w / Parents	91%	90%	89%	93%
Continuity of Relationship - Child w / Fathers	87%	89%	87%	90%
Continuity of Relationship - Child w / Mothers	94%	91%	91%	95%

[5] Four (4) cases were identified as N/A

C. Well-Being

Well-Being Outcomes 1, 2, and 3

Well-being outcomes include: (A) families have enhanced capacity to provide for their children's needs; (B) children receive appropriate services to meet their educational needs; and (C) children receive adequate services to meet their physical and mental health needs.

- For each of the three well-being outcomes, include the most recent available data demonstrating the state's performance. Data must include relevant available case record review data and relevant data from the state information system (such as information on caseworker visits with parents and children).
- Based on these data and input from stakeholders, Tribes, and courts, include a brief assessment of strengths and concerns regarding Well-Being Outcomes 1, 2, and 3.

State Response:

Well-Being Outcome 1:

ITEM 12

Preliminary results from the CT CFSR pilot and the most recent results from the Court Monitor for Outcome Measure 15: Needs Met suggest that Item 12- 12B is an in which the Department is not doing as well as it would like. Some data is as follows:

CFSR ITEM #	ITEM	% Strength
12	Needs and Services of Child, Parent and Foster Parent	50%
12A	Needs Assessment and Services to Children	73%
12B	Needs Assessment and Services to Parents	59%
Juan F. Measure	**ITEM**	**% Achieved**
15	Needs Met	57.4%

This is a known and persistent area of challenge for the Department. This outcome area is one of the items of priority under the 2015 and 2016 DCF Performance Expectations. DCF Regions have developed Operational Strategies to address how they will achievement improvement in this area. These Operational Strategies are reviewed by the Commissioner and her Senior Leaders every quarter. One of the strategies being undertaken by the Department to improve this outcome indicator is the implementation of Exceptional Case Planning (ECP). ECP requires that Area Office Managers are regularly reviewing the completed ACRis to discern areas needing improvement and the reasons that the items are not being rated as strength. Individual Support Plans (ISP) are created for staff who regularly struggle to achieve the expected level of attainment for the reviewed items. The ISP will identify how the staff will

be aided in improving their outcomes. This might include additional training and enhanced support during supervision.

The data for Item 12C: Needs Assessment and Services to Foster Parents, however, is very promising. It was rated as an 87.5% Strength. This is not too far off from the finding of DCF's 2015 Foster Care Satisfaction results in which 81.1% of survey foster parents indicted that DCF adequately assesses the foster parents' needs on an ongoing basis. 73.6% indicated that DCF was providing appropriate services to address identified needs.

ITEM 13:

Data from the CT CFSR pilots indicates that the Department is not achieving at the level it would wish for this item. Only 50% of the applicable reviewed cases (12 out of 24) were rated as a strength with respect to child and family involvement in case planning.

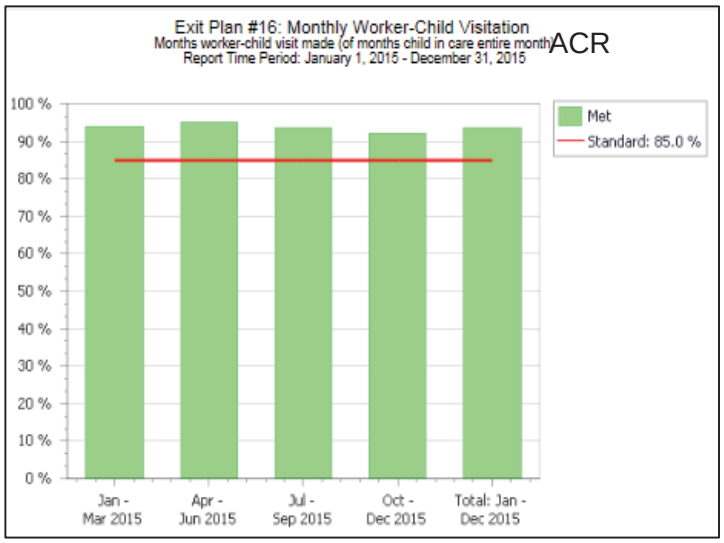
ACR attendance information (below) is another data point that gives some additional context to this item. These data too suggest that the Department needs to better support child and family involvement in case planning, including their attendance at ACR meetings. Further, data from DCF's recent Foster Care satisfaction study indicated that over a quarter of youth surveyed did not think that the ACR was beneficial. The Department's Office of Administrative Case Review is developing a plan to further examine this issue and eventually develop and employee youth identified strategies to increase participation in and youth's satisfaction with the ACR process. They will also be identifying strategies to increase ACR participation by fathers and mothers.

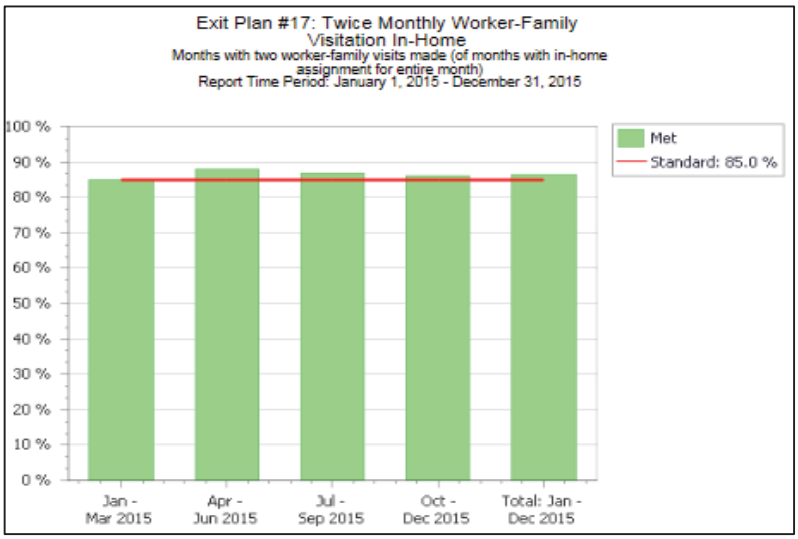
ACR Role	# Invited	# In-Person	# Tele-Conference	# Total Participating	% Total Participating
Youth (12+)	4,434	656	570	1,226	28%
Mother	9,996	3,566	1,781	5,347	53%
Father	8,969	1,712	1,163	2,875	32%

ITEM 14 + ITEM 15

Data from the CT CFSR pilot indicates that these items are areas in which the Department is not achieving at the level it wants. 58% of the reviewed cases were identified as a strength for Item 14. Only 18% of reviewed cases were rated as a strength for Item 15. This is certainly concerning and will need to be further examined. This is particularly so as these specific data are in contrast to the CT ROM data for CY 2015 for Caseworker Visits with Child and Caseworker Visits with Parents, and similar ACR findings, which do not have these items rated nearly as low. A possible reason for the different may be the cohort of cases in which these data reflect. For the past couple of years, the Department was observing decline in some outcomes due to staffing challenges. Last year, the Department was able to hire a significant number of new Social Workers. As the ACR and ROM data are for CY 2015, those data may be reflective of more current levels of attainments due to the infusion of additional staffing to better assure more frequent and quality visitation. Comprehensive training for ACR staff regarding CFSR standards, particularly regarding concerted efforts also occurred early CY 2015. Pre and post-testing from this training revealed that there was very inconsistent and incongruent understanding of and application of the federal CFSR standards and construction by ACR staff. Therefore, results from CY 2013 and 2014 are

not thought to be comparable in order to truly assess the impact of the new hires on the CY 2015 and CY 2016 attainment levels. Though, the first quarter CY 2016, which is reflective of the majority of the new hires having completed their training and having full caseloads is showing improvement from the CY 2015 data. Also, DCF social work staff were given training by ACR managers and the Regional QA to better understand the CFSR standards for concerted efforts, quality and frequency. The ROM and ACR data pertaining to Items 14 and 15 are presented below:





Measure	Statewide	
	2015	2016
	Strength	Strength
	%	%
Visitation with Child and Parents	63%	68%
Frequency of visits - Parents	63%	69%
Frequency of visits - Father	57%	64%
Frequency of visits - Mother	68%	73%
Quality of visits - Parents	65%	72%
Quality of visits - Father	59%	67%
Quality of visits - Mother	70%	76%
Frequency of visits - Child	75%	81%
Quality of visits - Child	76%	81%

Well-Being Outcome 2

Item 16

CY 2015 and CY 2016 ACR data suggest that the Department is doing well with respect to making concerted efforts to assess children's educational needs. The CT CFSR Pilot data finds this data to be rate as a

strength at the level of 79%, with an Outcome Rating of 79% Substantial Achievement and 5% Partial Achievement.

Given that the pilot is looking at cases with a PUR starting in 2014, it may be expected that the CY 2015 and CY 2016 is slightly higher given the addition of new social workers and the provision of ACR/CFSR items related training for social work staff last year.

ACR

Measure	Statewide 2015 Strength %	Statewide 2016 Strength %
Educational/development needs - Child	94%	94%
Education/development needs assessed - Child	95%	96%
Education/development needs addressed - Child	95%	95%

Well-Being Outcome 3

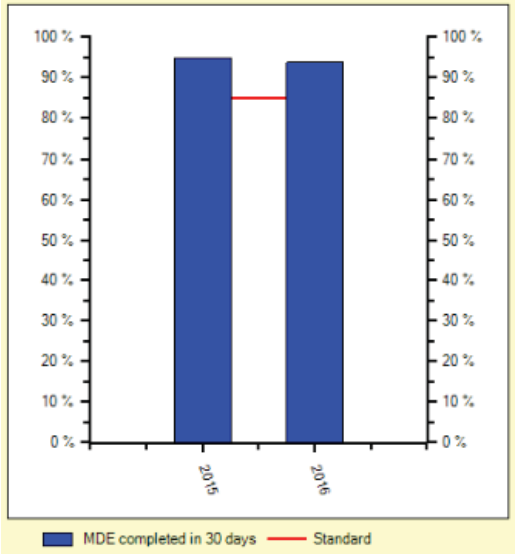
Item 17 + Item 18

ACR

Measure	Statewide 2015 Strength %	Statewide 2016 Strength %
Physical health care - Child	84%	85%
SA/Social Support/MH - Child	87%	88%
Physical health care needs assessed - Child	96%	95%
Physical health care needs addressed - Child	92%	92%
Dental health care needs assessed - Child	93%	92%
Dental health care needs addressed - Child	91%	91%
Vision needs - Child	95%	94%

Data from the CT CFSR Pilot suggests the Department is doing well to ensure that children received adequate services to meet their physical and mental health needs. The Outcome Rating for this outcome is rated as 87% Substantially Achieved and 5% Partially Achieved. The Strength rating for Item 17 is 94%. That for Item 18 is 87.5%. Furthermore, ROM and ACR data reveal similar findings.

ROM data regarding achievement related to timely receipt of Multidisciplinary Exams (MDE) is below. Under the Juan F. Consent Decree, children entering DCF care for first time must receive a MDE within 30 days. The purpose of the MDE is to identify, assess and recommend treatment for any acute and/or chronic medical, developmental, dental or mental health condition. Providers are required to submit a comprehensive written assessment within 15 days of the occurrence of an MDE. As these data demonstrate, the Department has been consistently ensuring that children receive an MDE at a level well above the 85% standard. Further, data for the last quarter of CY 2015 indicated that over 89% of the MDE assessments were being completed and sent to the Department within 15 days. These assessment are critical to not only the development of case plans but supporting the provision of individualized services.



Section IV: Assessment of Systemic Factors

Instructions

The statewide assessment information for systemic factors is used in determining ratings for substantial conformity. Therefore, it is imperative that the statewide assessment team ensures that information in this section speaks to how well each systemic factor requirement functions across the state. To complete the assessment for each systemic factor, state agencies should:

1. Review the *CFSR Procedures Manual* (available on the Children's Bureau Web site at http://www.acf.hhs.gov/programs/cb), which elaborates on key concepts and provides examples of data that are relevant to the assessment of systemic factor requirements.
2. Respond to each assessment question using the requested data and/or information for each systemic factor item. Relevant data can be qualitative and/or quantitative. Refer to the section in the state's most recent Child and Family Services Plan (CFSP) or Annual Progress and Services Report (APSR) that provides assessment information on state performance for each of the seven systemic factors. Review the information with the statewide assessment team and determine if more recent data is available that can be used to provide an updated assessment of each item. If more recent data are not available, refer to the most recent CFSP or APSR document by indicating the document name/date and relevant page numbers where the information can be found for each systemic factor item.
3. Emphasize how well the data and/or information characterizes the statewide functioning of the systemic factor requirement. In other words, describe the strengths and limitations in using the data and/or information to characterize how well the systemic factor item functions statewide (e.g., strengths/limitations of data quality and/or methods used to collect/analyze data).
4. Include the sources of data and/or information used to respond to each item-specific assessment question.
5. Indicate appropriate time frames to ground the systemic factor data and/or information. The systemic factor data and/or information should be current or the most recent (e.g., within the last year).

The systemic factor items begin with #19 instead of #1 because items #1 through 18 are outcome-related items covered in the onsite review instrument used during the onsite review. Items related to the systemic factors are items #19 through 36.

A. Statewide Information System

Item 19: Statewide Information System

How well is the statewide information system functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

> Please provide relevant quantitative/qualitative data or information that show the statewide information system requirements are being met statewide.

State Response:

As required, the Department can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care. A variety of processes exist to support and evidence the quality of these data. Related, a number of reports and constructions of these specific data are readily available to staff in order to innervate usage and inform practice.

For example, payments to foster parents and congregated providers are generated from the placement/location data in CT's SACWIS, LINK. This means that foster parents and congregate care providers will only be paid if an accurate and appropriate address of a child in care is put into LINK by his/her social worker. A review of fiscal data regarding checks mailed out to foster parents and congregate providers from December 2015 – February 2016 supports the quality of placement/location data at the child level. This review reveals that .07% (less than 1%) of the checks mailed out were returned. The Department mailed out 15,484 checks over the course of that 3 month period. Only 72 checks were returned due to it being sent to the wrong address or provider. The Department specific requires that checks are returned by the post office and not forwarded. When checks are returned, fiscal outreaches to the Social Worker to ensure that the errant address is updated according. The fact that foster care and congregate payment are intractably tied to the accuracy of the address in LINK serves to enforce the quality of that information.

Next, the Department's CFSR Data Profile (AFCARS Data Quality Checks) data indicates that demographic characteristics, such as age, is consistently well below the 5% threshold. As the chart below evidences, for age related items, the Department's error rate has been 0%:

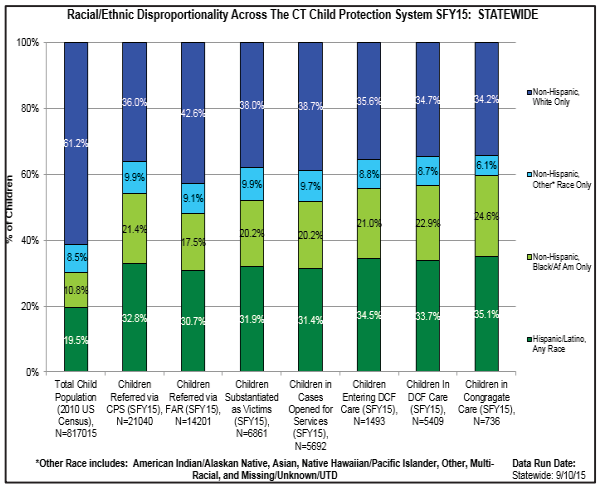
		Limit	MFC	Perm	PS	10B	11A	11B	12A	12B	13A	13B	14A	14B	15A
AFCARS IDs don't match from one period to next	>	40%	✓	✓	✓	23.0	22.0	23.8	19.3	22.9	20.2	23.1	21.3	22.8	
Age at discharge greater than 21	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Age at entry is greater than 21	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Date of birth after date of entry	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Date of birth after date of exit	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dropped records	>	10%	✓	✓	✓	0.9	2.4	7.0	5.8	7.1	6.1	7.2	9.3	**10.0**	
Enters and exits care the same day	>	5%	✓	✓	✓	0.0	0.0	0.3	0.2	0.3	0.3	0.3	0.3	0.0	0.0
Exit date is prior to removal date	>	5%	✓	✓	✓	0.0	0.2	0.4	0.1	0.2	0.3	0.3	0.3	0.0	0.0
In foster care more than 21 yrs	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing date of birth	>	5%	✓	✓	✓	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Missing date of latest removal	>	5%	✓	✓	✓	0.0	0.0	2.6	2.3	2.6	2.3	2.9	3.1	2.4	2.5
Missing discharge reason (exit date exists)	>	5%		✓		0.6	0.9	1.3	1.7	1.6	1.7	2.2	**1.4**	3.9	4.7
Missing number of placement settings	>	5%			✓	0.8	0.7	3.2	4.3	3.8	4.5	4.0	2.9	**5.2**	**6.7**
Percentage of children on 1st removal	>	95%	✓	✓	✓	77.3	77.4	77.6	78.0	78.1	78.2	77.8	77.9	78.6	79.4

The chart to the right shows race and ethnicity data for children in placement. The table below presents gender/sex data for children in placement. These data are presented in the "Plaintiff's Monthly Report," under the Juan F. Consent Decree. The low rate of blank and unable to determine (UTD) for race and

ethnicity (1%), as well as for gender/sex (1%), supports the fact that Social Workers are obtaining and inputting this necessary, demographic information.

Race	Gender	Age_Grp2 <1	1-5	6-12	13-17	>=18	TOTAL
Am.Ind/Al.Native	Female				1		1
	Male		1	3	4		8
	TOTAL	0	1	3	5	0	9
Asian	Female		3	4	7	1	15
	Male			2	3	3	8
	TOTAL	0	3	6	10	4	23
Black	Female	26	108	101	165	86	486
	Male	31	142	120	144	96	533
	TOTAL	57	250	221	309	182	1019
Multi-Race	Female	20	107	54	50	22	253
	Male	25	116	68	41	17	267
	TOTAL	45	223	122	91	39	520
Nat.Haw./Pac.Isl.	Female	1			1	1	3
	TOTAL	1	0	0	1	1	3
UTD	Female	1					1
	TOTAL	1	0	0	0	0	1
Unknown	Female	3	7	5	3	1	19
	Male	10	6	1	3		20
	TOTAL	13	13	6	6	1	39
White	Female	90	318	262	317	165	1152
	Male	86	373	295	312	154	1220
	TOTAL	176	691	557	629	319	2372
TOTAL		293	1181	915	1051	546	3986

Further, the Department's establishment of a Program Director position responsible for gender responsive services, an Office of Multicultural Affairs, a racial justice agenda (which is one of the Department's cross cutting themes) and a practice guide regarding caring for youth and caregivers who identify as transgender, also underscore the importance and value the agency places on ensuring that care is consonant with children and families cultural, racial, ethnic, gender and linguistic identification. Thus, accurate and complete data on children's demographic is driven not by a focus on compliance, but value of and recognition of its relationship to outcomes for children and families. See for example, the Racial/Ethnic Disproportionality Pathways data that the Department has created and publishes to it website.



Data as of March 18, 2016, indicates that there 2,861 under age 18 who are identified as pre-TPR (Termination of Parental Rights). Of those youth, 279 had a missing/blank case plan goal. Analysis of those 279 cases indicates that 263 (94.3%) have been open for less than two months. This suggests that the Department does a good job of ensuring that a case plan goal is identified and done so in a timely manner.

Race	Hispanic No	Hispanic Yes
White	1515	857
Black	942	77
Multi-Race	398	122
Unknown	18	21
Asian	21	2
Am.Ind/Al.Native	7	2
Nat.Haw./Pac.Isl.	2	1
UTD	1	
TOTAL	2904	1082

Case Plan Goal	Count
Adoption	571
Another Planned Permanent Living Arrangement	154
Long Term Foster Care Relative	18
Reunification	1429
Transfer of Guardianship: Non-Relative, Non-Subsidized	2
Transfer of Guardianship: Non-Relative, Subsidized	29
Transfer of Guardianship: Non-Subsidized	15
Transfer of Guardianship: Relative, Non-Subsidized	7
Transfer of Guardianship: Relative, Subsidized	113
Transfer of Guardianship: Subsidized	244
(blank)	279
Grand Total	**2,861**

The Department's Administrative Case Review process, which held nearly 14,000 ACR meetings last year, reviews the identified case plan goal(s). As the screenshot[6], below indicates this is data collected through the ACR assessment tool (ACRI).

Planning for Permanency	OM3- The case plan contains the identification of an appropriate case permanency goal and concurrent goal: There is an identification of a concurrent goal and plan if the case permanency goal is reunification and there is a lack of progress after 6 months of placement. There is a visitation plan for parents and siblings for cases involving a child in placement. It should describe the frequency, duration and type of visitation permitted between parents and their children, between siblings, and between other relatives as necessary. For the in home case plan, there must be a stated case goal.

A review of data for this element, for the period of January 1, 2015 – May 31, 2015, indicates that this was a strength for 94% of the cases (4,348 out of 4,626 reviews). The chart to the right presents the legal status of the 2861 children identified as pre-TPR.

Legal Status	Count
96 Hour Hold	11
Commitment Abuse/Neglect/Uncared For	2197
Commitment Dual	21
Commitment FWSN	1
Commitment Mental Health	1
DCF Custody Voluntary Services	3
Not Committed	45
Order Of Temporary Custody	577
Protective Supervision	5
Grand Total	**2861**

The AFCARS Data Quality Checks indicates that the "Dropped Records" limit is >10%. The Department's CFSR Data Profile indicates that the Department's was exactly at 10%. It should be noted that cases are categorized as having been dropped when they are left unresolved in one AFCARS file submission, and are missing from the next AFCARS submission. This does not mean that they are absent from CT DCF's SACWIS system. Instead, the values in specific fields on which the algorithm that determines when a child is discharged from an episode are not indicated correctly by the worker. Missing or incorrect LINK discharge information results in placement episodes being reported in AFCARS as open at the end of a specific reporting period. In the subsequent reporting period(s), however, if there is no further placement activity the child/youth is not

[6] *This is a copy of the hover text for this element on one of the ACR reports*

reported, thus appearing across multiple reporting periods as though the child was dropped. These cases are regularly identified as problematic by Information Systems staff that work in both Central and Area Offices, who then work with social work staff to make necessary corrections to the data. They are also often identified as problems by our social work staff, who then solicit assistance from IS to ensure the necessary corrections are made. The Department worked with the Regions this past January to redress the "Dropped Records data issue. All the records identified by CT's CFSR Data Profile as having been dropped have been updated.

The DCF Federal Reporting Team, which is housed in our Information Systems Division, following Federal guidelines, extracts data from our SACWIS system (LINK) in accordance with AFCARS, NCANDS, and NYTD standards: and uses utilities provided by each program, such as AFCARS (Data Compliancy, Data Quality, and Frequency), NCANDS (Extended Validation Application Analysis and the Year-Over-Year analysis provided by WRMA), and NYTD (NYTD Data Review Utility). As part of our process, we utilize these above tools to validate, and analyze quality and Federal business rules, and the distributions of data for proportional consistency of values year-over-year. For example, the compliancy, quality, and frequency tools look at discrepancies such as: "% of youth without dates of birth", "dates of death before a child was born", as defined in Federal validation rules.

Upon examining the reports produced by these utilities, we look at items that are abnormal, non-compliant, or questionable. We then look at our extract process, the SACWIS system, the business rules, and the business process behind the capture of related data, the data models, and the granular data behind each questionable item. This process has brought to light many issues which have been addressed with new releases to the SACWIS, data cleanup efforts including historical data, and changes in process and practice, as well as training and workgroup activities. The items status, demographic characteristics, location, and goals for the placement are all evaluated by multiple rules for each of the 66 AFCARS Foster Care elements, 37 AFCARS Adoption elements, 150 NCANDS Child File elements, and 58 NYTD elements (across two sets of populations served and surveyed). Because many of the items touch multiple elements, if more detailed information is necessary, a mapping exercise can be performed to identify federal elements.

In addition to the federal reporting metrics, we also have tools such as Lexis Nexis that allow DCF to access a complete person profile, including all known addresses and search one of the largest collections of public information in existence. This is a tool that can be used to look at registered addresses, and in the new CCWIS system we plan on having address validation functionality built in as a web service.

In the future, with the development of our CCWIS system, we hope that the agency disseminates the data quality information across all levels of worker, supervisor, management and executive staff – with appropriate views so that the quality of our data is examined at every level of practice. By having greater access to this data, the agency will be able to be more reactive, and agile in addressing issues with the timeliness, accuracy, completeness and consistency of the data.

The Department has been guided by the "AFCARS Data Compliance Utility Detailed Reports" to identify and support clean-up of data. The AFCARS Data Compliance Detailed report lists all of the errors found by the compliance utility. The vast majority of errors reported by the utility are due to missing data. The below sets forth the various data clean-up efforts and activities, by relevant element, that have occurred over the past several years. As the data generally reveal, ongoing efforts has significant reduced the

number of errant records. Connecticut's Data Profile further indicates that only two areas (out of 14) of the AFCARS Data Quality Check items were at or outside of the proscribed limit. One item was identified as at 10% and the limit is greater than 10% and for the other, one file submission was 5.2 whereas the limit was >5%. For the same item another file submission was 1.7 percentage points above the threshold.

Related, the Department has engaged in a variety of ongoing efforts to support the quality of data contained in LINK. So of that is presented below. This information demonstrates Connecticut's ongoing efforts and commitment to continuing to improve, in totality, the quality of its data; even for areas that may not be outside of AFCARS limits. In fact, a review of the below shows that in many instances there are only tens or sometime a few hundred records that need to be cleaned up out of those of cases. If the Data Profile document which is based on the AFCARS data checks is a measure of data quality, it does suggest that 86% of CT's CFSR items are well within the limit. CT has also achieved 100% compliance (0% errant) for 8 of the 14 items.

1. Foster Care

Removal Flag/Reason – AFCARS Element #18, #25 - #40.

Issue: Workers fail to answer this question. When any child is removed from the guardian's home and is placed in Foster Care, workers must identify the child's FIRST placement from home, the manner of removal and the removal reasons.

Action(s) taken:

Placement and Legal Streamlining (PALS): With the introduction of PALS in LINK, this effort was to streamline and synchronize the legal and placements. However, depending on who is entering the placements and their security level, a worker can "backdoor" a placement, that is, enter a placement without having to identify if it is a first removal, the manner of removal and reasons for removal. The "backdoor" path unfortunately will also allow a placement to be made without the legal completed.

Clean Up effort: IS in conjunction with the AO staff.

Data clean- ups done:

2015 – 42 records

2014 – 3,638 records

2012 – 17 records

Discharge Flag/Reason (Dropped Cases) – AFCARS Elements #56 - #58

When a child has exited care and has no subsequent placement(s) workers are not identifying the last ended placement as a discharge from all placements.

Clean Up effort: IS in conjunction with the AO staff.

Data clean- ups done:

2015 – 375 records

2014 – 403 records

2009 – 273 records

2006 – 826 records

Post-clean-up findings:

As clean up occurs, the number of records requiring clean-up has decreased

Dropped Cases:

This condition is the result of the above. Missing LINK discharge information results with placements being reported in AFCARS as open within a specific reporting period. However, in subsequent reporting periods, with no subsequent placement activity the youth is not reported in subsequent AFCARS files, thus appearing across multiple reporting periods as though the child was dropped.

Most recent case-plan goal – AFCARS Elements #43

In instances where APPLA was indicated in LINK, no permanency connections were provided, a condition required by AFCARS for data mapping purposes.

Action(s) taken:

LINK Release in 2012 with an addition to collateral contacts type of Permanent Connections

Clean Up effort: IS in conjunction with the AO staff.

Data clean- ups done:

2015 – 811 records

Post-clean-up findings:

Improvement in the data reported to AFCARS for this data element where APPLA/OPPLA applies

2. ADOPTION:

Was Mother Married at the time of Birth? – AFCARS Adoption Element #18

Issue: Workers failed to answer this question.

Action(s) taken:

LINK Release in 2010 with changes to force workers to enter this information

Clean Up effort: IS in conjunction with the AO staff.

Data clean- ups performed:

2015 – 17 records

2014 – 17 records

2013 – 63 records

2012 – 210 records

2010 - 105 records

2009 – 256 records

2008 – 1696 records

Post-clean-up findings:

As clean up occurs, the number of records requiring clean-up has decreased as time progresses.

Significant improvement in the data reported to AFCARS for this data element.

Missing TPR dates on Adoption – AFCARS Elements #19 and #20

On adoption records, the Adoption unit do not always receive the TPR dates on both parents on children who have been adopted. When this occurs, they cannot enter the info into the Adoption decree.

Action(s) taken:

Clean Up effort: IS in conjunction with the CO Adoption Unit.

Data clean- ups done:

2015 – 81

2014 – 418 records

Post-clean-up findings:

As clean up occurs, the number of records requiring clean-up has decreased as time progresses.

Significant improvement in the data reported to AFCARS for this data element.

Further, in November 2015, the Department launched an "AFCARS" Release to respond to a number of outstanding tasks with the goal of achieving compliance. A copy of that Release has been included as an Appendix. Some of the changes promulgated by that release were as follows:

- Placement Begin Time and Placement End Time fields have been added to the Out of Home Placement Service tab.

- The Multiracial checkbox has been disabled. You are able, however, to select more than one race. Such a selection will be interpreted as "Multiracial."
- A Safe Haven-Unknown checkbox has been added. When Safe Haven Baby is "Yes," the checkbox will be visible and selectable.

- On the pop-up that displays when "Abandoned" is selected from the Race window, the text now ends with "…and no person is available to identify the child's race." For AFCARS purposes, if the parent, relative or guardian is unwilling to identify a child's race, you should select "Declined/Not Disclosed."

- You are now able to indicate Hispanic/Latino ethnicity in either of two ways:
    - If you select one or more ethnicities, the Hispanic/Latino Origin: checkbox will also be selected.
    - If you check the Hispanic/Latino Origin: checkbox, you will be required to select at least one ethnicity in order to continue

- Under the Child in Placement Case Plan screen, the Permanency Plan tab has been modified to distinguish a goal of guardianship to a relative from a guardianship to a nonrelative. Also, per recent state legislation related to child permanency, the option indicating long-term foster care with a relative has been eliminated.

- If you select a Permanency Plan Goal of Another Planned Permanent Living Arrangement (APPLA) for a youth, it is necessary that you go to Case Contacts Information Details and enter a Permanent Connection to an adult under Additional Information, if one exists. For this purpose, a permanent connection is defined as a person who will help the youth transition to adulthood. With APPLA, this should be an active relationship.

- When you are closing a TPR case with the reason Subsidized Adoption or Non-Subsidized Adoption, an Adoption Plan is required. If one is not present, the case cannot be closed.

- The release also includes changes to the procedure for completing form DCF 603, *DCF Notification to the Local Education Agency*.

The Department will soon be launching an updated version of the Result Oriented Management (ROM) system. This reporting tool receives a feed from our SACWIS, LINK, to populate the various ROM reports. An added feature within this enhanced version of ROM is the inclusion of a "Data Exception" report. This specific report will better aid the Department to identify and clean up missing and anomalous data, thereby positively influencing our data's quality.

The Department is in the process of procuring for a new SACWIS system. A great deal of work has occurred to map the current "As Is," system and to flesh out the components of the "To Be" SACWIS. In particular, the Department has identified some key "pressure points" that it will seek to ameliorate through the new SACWIS. Currently, as the above noted, the Department has made efforts to enhance LINK to better support entry of quality data. See attached Appendix to see a recent update to LINK for such purpose.

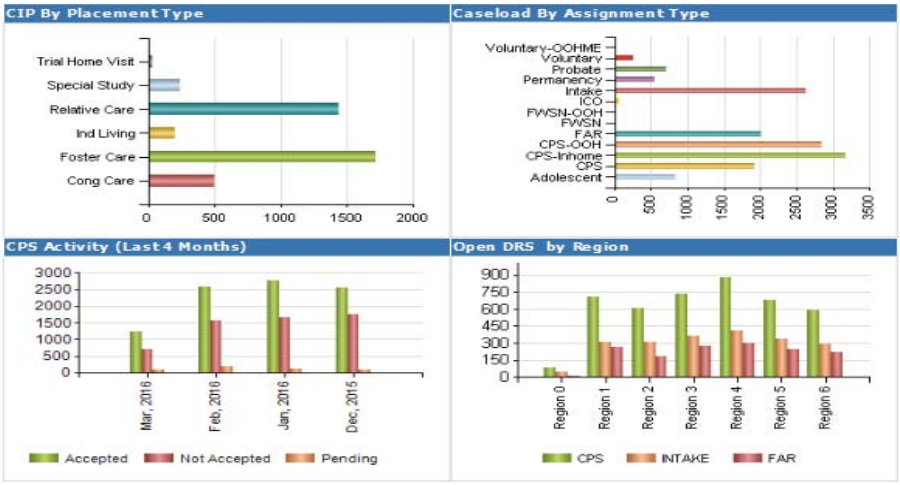
In addition, DCF's Information Systems team is identifying areas that impact quality. For example, Area Office LINK Specialist we asked to identify the top five areas that take up the majority of their time. One LINK Specialist noted that time was spent merging duplicate cases generated by the Careline. An analysis of this issue identified some areas for improvement (e.g., enhancing the sensitivity of the "sounds like" function in the case search feature; additional training on the searching protocol). Thus, IS will be partnering with the Careline to train their staff about the expected search protocol to reduce the creation of duplicated records and the need to merge cases. (e.g., searching at both the case and child level to better reduce duplicate case creation).

Next, the Department has invested heavily in creating a data environment and culture. The Department has worked diligently to actively use it data, thereby better supporting and reinforcing the importance of accurately, timely and complete data. This is facilitated by not only the Department's cross-cutting themes and annual Performance Expectations, but the Department's undergirding values (e.g., racial justice/disproportionality and disparity elimination, relative care, congregate care education, gender responsive services, and reduction in APPLA/OPPLA).

Consonantly, the Department has created a number of data dashboards and portals that allow agency staff to access and use the data that are required to be inputted. These reports allow staff to readily and easily glean information about things such as the numbers of children in care, their placement settings, their demographics, their status and their goals. These dashboards pull data from DCF's statewide information system, LINK. Many of the dashboards can be filtered to review the data by age, race/ethnicity, gender and Region/Area Office. These data can also be drilled down to the child level by clicking on the data. It will open as a child or case level dataset that contains a host of data variables that can be exported into Excel for further analysis. LINK reports are generally refreshed daily.

A screenshot of the LINK Reporting switchboard is as follows:

The below displays another dashboard that present caseload by assignment, including distinguishing CPS-Out of Home (foster care) versus CPS-In Home. These data are also from LINK reflecting placements as of March 12, 2016:



The dashboard below, for March 1, 2016, shows the Statewide Child in Placement data. It shows the distribution of children in foster, relative care, special study care, and the percentage of children in congregate care settings. It also shows the percentage of initial placements into relative care. These data are available by Region and Area Office. Other versions of this dashboard allow for filtering by age cohorts, race/ethnicity, and gender. A variety of other reports are also easily accessible and available to staff. These reports can be drilled down to raw dataset by clicking on any aggregate number of interest. These datasets contain data on the individual child record/tuple level.

These reports are important to Connecticut as it contextualizes location data and grounds it to the Department's goal and desire to prioritize children's placement in families, especially relative care. Data from January 1, 2011, revealed that only 21% of children in placement were residing with kin. Data as of

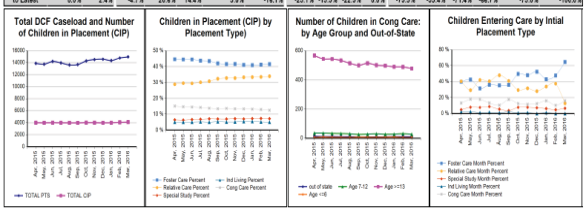
March 1, 2016 indicate that over 41% of children are placed with kin, a 63% increase. Relatedly, nearly 30% in DCF care were in a congregate care setting on January 1, 2011.[7] That has dropped to 12.4%; a 64% reduction. This CIP report is posted on the Department's external website.

Total Caseload Points and Children-in-Placement (CIP) Distributions April, 2015 to March, 2016

Statewide

State	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6

CIP DASHBOARD			% of Total Children-in-Placement (CIP)					# in Congregate Care Subgroups			# and % of Children Entering Placement During Time Period					
			Family Foster Care						Age Group			Kinship Care				
Observation Date	Total Caseload Points	Total CIP	Foster Care	Relative Care	Special Study	Independent Living	Congregate Care	Out of State	>=13	7-12	<6	Entries During Period	Relative Care	Special Study	Foster Care	Congregate Care	Independent Living
04/01/2015	13,879	4,007	44.6 %	28.8 %	6.4 %	5.0 %	15.1 %	13	557	35	5	151	40.4 %	4.6 %	39.7 %	13.2 %	2.0 %
05/01/2015	13,737	3,989	44.5 %	29.5 %	6.3 %	5.0 %	14.7 %	11	543	36	8	178	29.2 %	7.9 %	42.7 %	18.0 %	2.2 %
06/01/2015	14,193	4,008	44.5 %	29.4 %	6.6 %	5.0 %	14.5 %	11	542	33	6	166	42.2 %	7.6 %	31.4 %	17.8 %	1.1 %
07/01/2015	13,955	3,996	43.7 %	30.1 %	6.8 %	5.2 %	14.3 %	10	532	32	6	196	40.5 %	8.7 %	35.9 %	13.3 %	1.5 %
08/01/2015	13,614	3,986	43.4 %	30.8 %	7.0 %	5.0 %	13.7 %	10	513	30	5	227	48.0 %	5.3 %	35.2 %	10.6 %	0.9 %
09/01/2015	13,679	3,975	42.6 %	32.4 %	7.0 %	5.3 %	13.4 %	9	499	26	6	196	40.9 %	3.5 %	35.9 %	17.7 %	2.0 %
10/01/2015	14,279	4,022	41.5 %	32.8 %	6.9 %	5.1 %	13.6 %	9	513	28	7	143	29.4 %	7.7 %	49.7 %	12.6 %	0.7 %
11/01/2015	14,519	4,008	41.6 %	32.8 %	7.1 %	5.1 %	13.4 %	9	500	30	6	181	31.5 %	7.7 %	48.1 %	11.6 %	1.1 %
12/01/2015	14,575	3,984	41.0 %	33.3 %	7.0 %	5.4 %	13.3 %	9	496	27	7	168	28.0 %	7.1 %	52.4 %	12.5 %	0.0 %
01/01/2016	14,338	4,001	40.9 %	33.4 %	7.2 %	5.4 %	13.1 %	11	489	28	8	181	33.7 %	6.1 %	43.1 %	16.0 %	1.1 %
02/01/2016	14,764	4,064	41.1 %	33.5 %	7.3 %	5.1 %	12.9 %	10	488	31	5	174	37.4 %	4.6 %	47.7 %	10.3 %	0.0 %
03/01/2016	14,987	4,105	41.5 %	33.9 %	7.2 %	5.0 %	12.4 %	10	477	27	5	31	12.9 %	6.5 %	64.5 %	16.1 %	0.0 %
% Change from 4/1/2015 to Latest		8.0%	2.4%	-4.7%	20.6%	14.4%	3.9%	-16.1%	-23.1%	-15.3%	-22.9%	0.0%	-79.5%	-93.4%	-71.4%	-66.7%	-75.0%	-100.0%



Last, the Department is prioritizing permanency for all children and youth who come into DCF care. As noted in this document, Permanency Teaming is an approach that the Department is using to support permanency planning for children/youth in foster care or at risk of entering the foster care system. The desired outcomes of permanency teaming are to identify a legal parent; achieve legal permanence or establishment of a nature network of supportive relationships. Implementation of Permanency Teaming is underway. Thus, the Department has created an OPPLA dashboard to monitor this goal.

OPPLA is a goal that the Department is working hard to reduce. Also, recent legislation prohibits this designation for youth under 16. Making this report available aids the Department in not only readily evaluating it overall progress in reducing the number of youth with an OPPLA designation, but also to determine whether there are any youth under 16 currently identified as having an OPPLA goal. A copy of the OPPLA report is posted on the Department's website. It should be noted, that this particular posted report shows all youth with an OPPLA goal, including those 18 and older. The internal version of this report, however, can be filtered by age (as well as gender and race) so that youth under 18 are discernable.

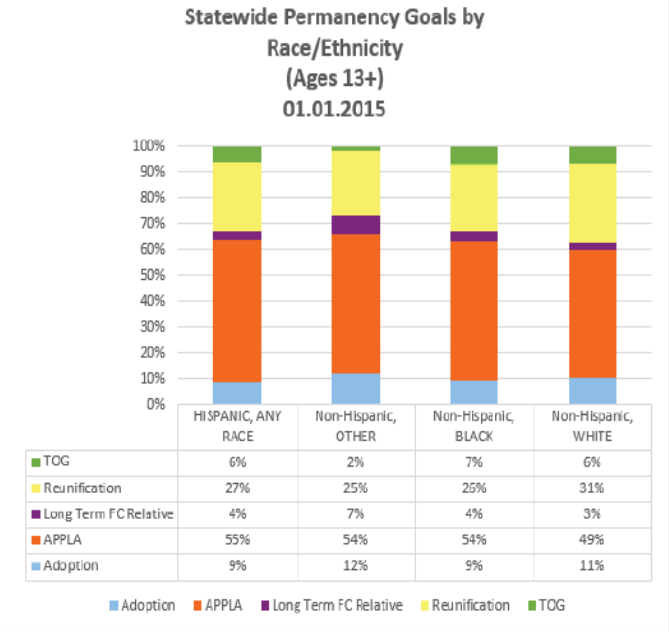
On June 1, 2015, there were 374 youth between the ages of 7-12 (N=10) and 13-17 (N=364) who have an OPPLA goal. Point in time data from October 2014 indicates that 491 youth between the ages of ages 7-12 (N=14) and 13-17 (N=477) had an OPPLA goal. Presently, data as of March 1, 2016, indicates that 207[8] total youth under 18 have an OPPLA goal. This is a reduction of nearly 81% since June 2015. It should be noted that in Connecticut the court is required to approve permanency goals. Thus, the Department has been working with judicial through regular meetings to enhance discussions regarding permanency and the reduction of OPPLA. These data demonstrate the progress the Department has made in the last year and even past 6 months to reduce the number of youth with OPPLA goals. It is expected that the full implementation of Permanency Teaming will have an even greater reductive impact on the number of youth with OPPLA goals.

In addition, the Department has created Permanency Goal datasheets for each of the Regions to support recent permanency forums with judges and community providers. As noted above, the court has an integral role with goal approval in Connecticut. Thus, producing these data and sharing these data are critical to supporting and monitoring progress in this area. An example of the goal data that has been created for each of the DCF Regions and Areas is as follows:

---

[7] *Congregate care is defined by DCF as any placement setting that has any form of 24 hour staffing (non-family based)*

[8] *1 child under 13 is currently identified as having an OPPLA goal. 15 youth between the ages of 13-15 are identified as having an OPPLA goal. The remaining 181 youth under 18 with an OPPLA goal are ages 16-17.*



Race/Ethnicity	Adoption	APPLA	Long Term FC Relative	No Goal[2]	Reunification	TOG	Grand Total
HISPANIC, ANY RACE	46	292	19	52	142	31	582
Non-Hispanic, OTHER	14	62	8	14	29	2	129
Non-Hispanic, BLACK	45	264	21	86	126	33	575
Non-Hispanic, WHITE	57	259	15	26	165	33	555

Finally, as suggested, the Department is enhancing its partnerships with the judicial branch. In particular, the Department has developed a plan through the Capacity Building Center for States whereby CT will be receiving technical assistance with respect to how DCF and the Courts can better support timely permanency for children. The Commissioner, a former CT Supreme Court Justice and our Chief of Staff, a former attorney with the CT Judicial Branch, meet regularly with the Judge who is the Chief Court Administrator for Juvenile Matters to aid with these discussions. Information about the Round 3 CFSR process and those outcomes and items that intersect between DCF and the Courts has been shared with the Judicial branch.

The below are some data that the Judicial branch provided allowing the Department to more fully examine CT's Termination of Parental Rights process. Some of these are Court Performance measures that are used for the State Court Improvement Grant and Plan. As the data reveal there are some in timeliness that the Department will need to monitor (e.g., % of petitions filed within 15 months). We will continue to partner with the Courts and further explore how we can jointly support the expeditious but appropriate granting of a TPR petition.

Time to Filing Termination of Parental Rights Petition

Explanation:
Where reunification has not been achieved, Average (median) time from filing of the original petition to filing of the petition to terminate parental rights. This is a Court Performance measure that is calculated for or State Court Improvement Grant.

Cohort: All TPR petitions filed during FY15

FY14/15						
# TPR filed	# within 15 months	# within 24 months	Average	Median	% Within 15 months	% Within 24 months
511	294	426	552	426	58%	83%

Time to Filing of Parental Rights Petition from Removal Date

Explanation:
Average and median time **in months** from removal date to filing of the petition to terminate parental rights. This is based on the removal date of the child (date of 96-hour hold, OTC or Commitment order) to the date the termination of parental rights petition was filed.

Cohort: All TPR petitions filed during FY15

FY14/15						
#TPRs Filed	# Within 15 months	# Within 24 Months	Average	Median	% Within 15 months	% Within 24 Months
511	332	441	16	13	65%	86%

Time to Termination of Parental Rights

Explanation:
The number of days from filing of the neglect/uncared for/abused petition to the time the termination of parental rights is granted. Both the median and the average have been calculated. This is a Court Performance measure that is calculated for or State Court Improvement Grant.

Cohort: All TPR petitions disposed during FY15

FY14/15					
# Disps	Average	Median	Within 12 months	Within 24 months	Within 36 Months
515	751	656	9%	62%	87%

B. Case Review System

Item 20: Written Case Plan

How well is the case review system functioning statewide to ensure that each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions?

Please provide relevant quantitative/qualitative data or information that shows each child has a written case plan as required that is developed jointly with the child's parent(s) that includes the required provisions.

State Response:

The Office of Administrative Case Review (OACR) is a statewide operational unit responsible for the Administrative Case Review (ACR) system across the six (6) regions of the Department. As the cornerstone of the Department's Continuous Quality Improvement (CQI), the OACR is helmed by a Program Director (PD) who reports to the DCF Chief of Quality and Planning. Four (4) Program Managers are assigned to oversee the daily regional operations of the ACR process, which includes the direct supervision of fifty-two (52) ACR Social Worker Supervisors (SWS) who sit in the Area Offices.

The ACR process assures that each child has a case plan designed to achieve placement in a safe setting that is the least restrictive, most appropriate and in close proximity to the parents' home, consistent with the best interest and specialized needs of the child. DCF Policies 36-1 through 36-5, "Case Planning" and 36-11-1 through 36-11-2, "Administrative Case Review", in conjunction with the Case Planning Practice Guide (issued March 2014) provide agency social workers key information as it relates to best practice guidelines around case planning with children and families. These guidelines not only include timeframes for the development of case plans, but also include salient information with regard to the development of case plans with families and children, specifically active engagement throughout the case planning process. As part of the case review, the ACR Supervisor also ensures the case plans being reviewed include the required provisions, and documents the findings in the Administrative Case Review Instrument (ACRI). The completed ACRI is then provided electronically to the social worker, supervisor and manager of the case with specific information and feedback related to the required provisions. A blank copy of the ACRI is included as an Appendix.

In preparation for the ACR, the OACR SWS conducts a comprehensive case review of the electronic record, which includes reading the case narratives for the entire period under review (PUR), which can be sixty days if the child newly entered care, or up to six months if the child has been in care and this is a subsequent review. The ACR SW also reviews the written case plan, which must be submitted to them by the CPS social worker seven (7) days prior to the meeting, though the agency does allow for case plans to be submitted up to three (3) days before the ACR date. Any case plans that are submitted to the ACR SWS with less than three (3) days before the review are rated as "no case plan" (not timely case plan). This data

	Statewide			
	2015			
	Strength		ANI	
Measure	#	%	#	%
Timely Case Plan	12392	95%	656	5%

element is tracked and reported out on by regional office leadership as the Department is committed to ensuring that all children have a written case plan. In CY 2015, the Department achieved having a "Timely Case Plan" in 95% of the total case plans rated for this item. Again, the timeliness as rated in the Case Practice Report is in relation to the ACR meeting date and ensures that a written case plan is provided to the ACR SWS in advance of the review meeting. Following the ACR meeting, social work supervisors are required to approve the reviewed case plan within ten (10) days of receipt of the ACR supervisor's feedback, but no later than twenty-five (25) days following the ACR meeting.

Measure	Statewide 2015 Strength #	Strength %	ANI #	ANI %
Timely Case Plan	12392	95%	656	5%

Age of Cil	No Plan?
1	1
2	1
3	1
4	1
7	2
8	2
9	2
13	2
14	2
15	4
16	4
17	7
Grand Total	29

The Department also has an "Exception Report" which identifies children in placement (CIP) for whom there is not a current case plan in LINK within 180 days. According to the CIP Dashboard report for 1/1/16, there are 3,998 CIP and of those, twenty-nine (0.7%) of children in care, ages 0-17, appear on this report as having no current case plan within 180 days of either the most recent case plan or entry into care .

In reviewing the narratives and through discussion at the review meeting, the OACR SWS is responsible for assessing a variety of case practice indicators that highlight family and child/youth engagement in case planning, including the "family feedback" documented by the social worker in the case plan. In this section, the social worker reflects on the family's feedback as related to case planning, case goals and progress. These indicators provide the Department with critical information related to case planning and engagement. Following facilitation of the ACR meeting, the OACR SWS enters their assessment and findings into the Administrative Case Review Instrument (ACRI) which is used to feed the Department's Case Practice Report, a report that provides the agency valuable information with regard to case practice and outcomes for children and families.

Case Practice Report

The Case Practice Report identifies areas of strength and areas needing improvement fo

Parents are defined as biological parents, adoptive parents, guardians, psychological par prior to removal, and assessed in the ACR process.

User may view additional areas of case practice by clicking in the Measure box. The repo

Actions | 1 of 1 | Find Next | 100%

Last Page

Sl.No	Measure	Statewide 2015 Strength #	Strength %
1	Visitation with Child and Parents	5469	63%
2	Frequency of visits - Parents	8113	63%
3	Frequency of visits - Father	3232	58%
4	Frequency of visits - Mother	4881	68%
5	Quality of visits - Parents	8418	66%
6	Quality of visits - Father	3374	60%
7	Quality of visits - Mother	5044	70%
8	Frequency of visits - Child	9181	75%
9	Quality of visits - Child	9334	76%
19	Parent Needs	3101	72%
20	Needs Assessed - Fathers	2897	74%
21	Needs Assessed - Mothers	3600	83%

Based upon ACRs held in CY 2015, the Practice Report highlights the Department's strengths in some of the practice indicators that have a strong correlation to quality case planning and family engagement. The numbers for each indicator vary because they are based on the individual participants, not the total number of meetings held. The Department's "Purposeful Visitation Guide" and "Case Planning Practice Guide" both emphasize the importance of family engagement in case planning and the direct connection to visitation with parents and children. ACR SWS utilize this lens as they assess case practice during their reviews.

In preparation for Round 3 of the CFSR, the agency conducted pilot reviews utilizing the OSRI and OMS. As a result the agency was able to utilize OMS reports to assess performance across all items, including Item 13, Child and Family Involvement in Case Planning. The pilot data reflects a strength rating in 50% of the eighteen (18) cases rated for this item and often where there were areas noted as needing improvement, there was a connection to the frequency and quality of visitation. Likewise, in those reviews where involvement in case planning was noted as a strength, there was evidence of ongoing discussions with the child and parents specific to case planning and in interviews, parents and children acknowledged their inclusion in case planning. The feedback obtained in DCF's CFSR Phase 2 and Phase 3 pilots is consistent with the feedback the ACR supervisors have provided through their case reviews and have documented in the ACRI.

Currently, the ACR notifications are generated through LINK, the agency's SACWIS system. When a child enters placement for the first time or when a child remains in care and it is 120 days since the most recent case review a notification occurs. This allows for a 60 day window for the next review to be scheduled. This automated system helps the Department to ensure that each child has an ACR scheduled, at which time the written case plan will be reviewed with the family and other invited participants. Each regional office has an Office Assistant who is responsible for scheduling these case reviews.

Areas for Improvement:

While the ACR process is valuable in ensuring each child has a case plan and that the plan is developed jointly with the child's parent(s) and includes the required provisions, there are gaps in this system as well. As referenced earlier, the notification to an Office Assistant to schedule an ACR meeting is triggered by a child's placement as documented in the SACWIS System. However, if there are data quality issues with the entry into SACWIS, notifications will not be generated. For example, if the removal flag is answered incorrectly, the system does not identify this child's entry as new and will not send the automated notification for ACR scheduling. Similarly, if the CPS supervisor does not approve a placement in LINK, notifications due for an ACR are not triggered, or are delayed based upon when the supervisor approved the placement. With over 40% of the agency's CIP in relative/kin care, issues also arise with regard to placements not being able to be documented in SACWIS immediately. While CPS staff are responsible for maintaining their own tickler's for case planning, there are times when case plans are not completed timely.

Finally, with the sun-setting of agency's OM 3 report, there is no single element or data point to identify agency performance around family engagement in case planning. Instead, engagement is an assessment that is currently embedded in the "case plan assessment" summary, and unable to be reported on in isolation.

Item 21: Periodic Reviews

How well is the case review system functioning statewide to ensure that a periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

> Please provide relevant quantitative/qualitative data or information that show a periodic review occurs as required for each child no less frequently than once every 6 months, either by a court or by administrative review.

State Response:

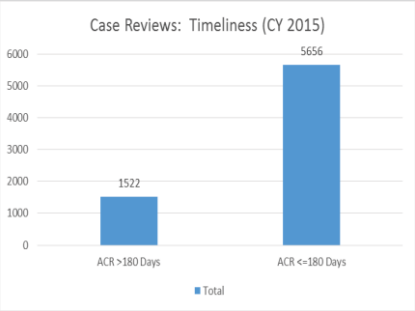
Through automated notifications built into the SACWIS system, the agency's case review system has been designed to ensure that a periodic review for each child occurs at least once every six (6) months through the Administrative Case Review (ACR) process. As a child enters care and the entry is documented in LINK, there are triggers to alert the ACR Office Assistant and the CPS staff that an ACR meeting needs to be scheduled within 60 days of entry into care, and a case plan written and submitted in advance of that meeting. Similarly, following the first ACR, the system is designed to automatically calculate the due date for the next review, 180 days from the last ACR, and automated notifications are sent beginning at the 120th day.

There are several automated reports utilized by the ACR Office Assistant (OA) to ensure all reviews that should have been scheduled are in fact scheduled in the appropriate time period. The primary reports are the "Proposed/Due" report and the "Anticipated" report. As new entries into care are documented in SACWIS, the data populates the "Due Report" and office assistants run this weekly to schedule reviews timely. This report identifies the maximum due date for a case review to occur (180 days) and the OA schedules accordingly. Once a case plan review has been conducted for a child in care, as long as s/he remains in care, the anticipated report automatically calculates the due date for the next case review and that date will reflect in the "anticipated" report, which allows for advanced scheduling of reviews.

The following table reflects the case reviews in 2015 for children in care under the age of 18 in 2015; when cross-walking this data with the "due report" for 2015, there are no children in care under 18 for whom a case review was not conducted. Some of these reviews were not timely, but through ongoing review of the reports, OA's are able to identify any reviews that may not have been scheduled.

Office	CIP <18 Reviews
Bridgeport Office	544
Danbury Office	324
Hartford Office	1181
Manchester Office	588
Meriden Office	360
Middletown Office	238
Milford Office	479
New Britain Office	712
New Haven Office	593
Norwalk Office	259
Norwich Office	871
Torrington Office	250
Waterbury Office	900
Willimantic Office	658
Grand Total	**7958**

The agency has a report to assess the attainment in reviewing cases at least every 180 days. For CY 2015, the data shows that 78.8% of the ACRs for children in care were held within 180 days and 97.5% of these reviews were held within 210 days from the last review, within 30 days of the due date. Of those reviews held beyond 180 days, 42.2% went beyond by only 1-5 days, and 60.7% went over by 1-10 days.



It is noted, however, that about 10% of the ACRs in the SACWIS system do not have a "proposed" or due date identified in the meeting window field, so these were excluded from the timeliness data. It is likely that the number of meetings held within 180 days is actually higher because often those meetings without a "due date" indicated in the SACWIS system are those that the office assistants manually create in the system to ensure these meetings are held timely. This is an issue that was previously identified in the 2008 CFSR. The OACR Management team has begun data reviews related to this issue and also received feedback from the Office Assistants (OAs) responsible for scheduling these meetings. For example, if a child enters care and is placed with a relative, if that relative is not yet in the LINK system as a licensed provider, the social worker is unable to reflect that placement in LINK, which results in no notification to the Office Assistant that a meeting is due to be scheduled within sixty (60) days. As a work around, some of the OA's will review the new placement logs and manually create meeting windows for any child the automated notification was not sent for. This results in the report not being able to calculate whether or not the ACR was held timely because the "proposed" or due date is "null".

# Days Beyond 180	Total Beyond 180 Days	
1-5	642	42.2%
6-10	281	18.5%
11-30	415	27.3%
>30	184	12.1%
Grand Total	**1522**	100.0%

Data from a Foster Care Survey conducted by the Department in 2015 offered the following findings with respect to how foster parents and youth respectively viewed aspects of the ACR process. The results from youth reflect some areas of concern, particularly with respect to their perception of the value of the ACR. Based upon this feedback, the OACR leadership team is developing a plan to outreach to youth to further assess this issue and identify strategies and formulate strategies to enhance the benefit of the ACR for youth.

Foster Parent Response:

Child's ACR being held at a convenient time for foster parent	152/204	74.5%
ACR beneficial for the child	160/198	80.8%
Foster parent's participation in ACR beneficial for the child	178/197	90.4%

Youth Response:

ACR being held at a convenient time	98/129	76.0%
ACR beneficial to the child	91/125	72.8%

Areas Needing Improvement

There are data quality issues that need to be reviewed in an effort to allow the agency to more accurately report on the timeliness of ACR meetings. The work related to this is ongoing and involves the ACR Program Managers, the Regional QA Managers, IT and CPS leadership. There are areas for improvement both on the data entry and reporting sides.

Item 22: Permanency Hearings

How well is the case review system functioning statewide to ensure that, for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

> Please provide relevant quantitative/qualitative data or information that show a permanency hearing as required for each child in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter.

State Response:

ACR Social Work Supervisors, as part of their case review for children in care, assess the timeliness of permanency hearings to ensure that a hearing occurs no later than twelve (12) months from the date the child entered foster care and no less frequently than every twelve (12) months thereafter. A review of the ACR data for this element, as related to case reviews conducted during CY 2015, reflects that in nearly 93% of the reviews, permanency hearings were found to have occurred within twelve months from the date of entry into foster care and 88.7% occurred no less frequently than every twelve (12) months thereafter.

	Yes	No	Grand Total
Hearing with in 12 Months	4171	323	4494
Hearing with in 12 Months	92.8%	7.2%	100.0%

	Yes	No	Grand Total
ThereAfter 12 months	4133	527	4660
ThereAfter 12 months	88.7%	11.3%	100.0%

The court also provides the agency with data for "time to subsequent permanency hearing" which is a Court Performance measure that is calculated for the State Court Improvement Grant. For the children who exited care in FY15, the percentage of permanency plan dispositions that were held within 365 days of the prior permanency plan disposition was 94%.

FY14/15				
#PP	# Within 365 Days	Average	Median	%Within 365 days
2092	1962	306	311	94%

In state conducted CFSR pilot reviews, Item 5 was rated a strength in 82% (9) of the eleven (11) cases reviewed.

Item 23: Termination of Parental Rights

How well is the case review system functioning statewide to ensure that the filing of termination of parental rights (TPR) proceedings occurs in accordance with required provisions?

Please provide relevant quantitative/qualitative data or information showing that filing of TPR proceedings occurs in accordance with the law.

State Response:

The ACR process ensures that the filing of termination of parental rights (TPR) occurs in accordance with required provisions. As part of the ACR meeting preparation and case review, the ACR Social Work Supervisor is responsible for reviewing the placement information for the child and documents the findings on the Administrative Case Review Instrument (ACRI). The ACRI has specific questions related to the time in care and specifically, the filing of TPR for those children in care >=15 cumulative months in the last 22 months.

	Yes	No	Grand Total
in care >=15 months cumulative in last 22 months?	3313	3917	7230
	45.8%	54.2%	100.0%

During CY 2015, ACRI data reflects that 45.8% of the reviews reflected that children were in care 15 or more of the most recent 22 months. It is important to note that the data is based on ACRs, so children who had two ACR meetings during this timeframe, and were in care 15 or more months at the time of review, are likely reflected twice (once for each review).

As part of the case review, the ACR supervisor documents not only whether or not a child has been in care 15 or more months cumulative in the last 22 months, but also whether or not a TPR has been filed. In reviewing these data, there appear to be areas needing improvement and clarification within the ACRI, and how these questions are answered by ACR supervisors during the review based on some inconsistencies identified. In order to assess the filing of TPR in accordance with required provisions, the current ACR data would not be the most accurate or reliable. The agency does, however, capture this data in the Exit Plan Monthly Plaintiff Report (table to the left).

Children <18 in Care 15+ Months and TPR Filing Status			
TPR Filed	Permanency Goal	#	%
YES	Adoption	155	15%
	APPLA	20	2%
	TOG: Sub	20	2%
	Reunification	15	1%
	(Blank)	2	0%
	TOTAL	212	21%
NO	Reunification	270	26%
	Adoption	178	17%
	TOG: Sub	224	22%
	APPLA	122	12%
	LTFC Relative	16	2%
	TOG:Non-Sub	7	1%
	(Blank)	4	0%
	TOTAL	821	79%
TOTAL	TOTAL	1,033	100%

In a report run March 6, 2016, the data reflects that for approximately 79% of the children under 18 who have been in care for fifteen (15) or more months, TPR has not been filed. In reviewing the data, specifically for those children in care fifteen or more months where no TPR petition has been filed, the documentation reflects that for 26% of these children there is a documented reason for not filing TPR. For approximately 74% of the 821 children, there is no documented reason in the record as to why the agency has not filed for TPR, which means that for these 606 children, either the agency should have filed and hasn't, has filed and did not document the filing in the SACWIS system, or there is a reason for not filing and the agency has not documented this in the electronic case record.

"Time to filing a Termination of Parental Rights Petition from Removal Date" is a Court Performance measure that is calculated for the State Court Improvement Grant. The following table was provided to

the agency by the court for the cohort that includes all TPR petitions filed during FY15. The data is based on the removal date of the child (date of 96 Hour Hold, Order of Temporary Custody or Commitment order) to the date the Termination of Parental Rights Petition was filed.

FY14/15						
#TPRs Filed	# Within 15 months	# Within 24 Months	Average	Median	% Within 15 months	% Within 24 Months
511	332	441	16	13	65%	86%

Item 24: Notice of Hearings and Reviews to Caregivers

How well is the case review system functioning statewide to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to be heard in, any review or hearing held with respect to the child?

Please provide relevant quantitative/qualitative data or information that show foster parents, pre-adoptive parents, and relative caregivers of children in foster care (1) are receiving notification of any review or hearing held with respect to the child and (2) have a right to be heard in any review or hearing held with respect to the child.

State Response:

	Yes	No	Grand Total
Letter Generated 21days Before Meeting	31,700	35,595	67,295
	47.1%	52.9%	

Caregiver Type	Timely Notice		Not Timely		Total
Adoptive Parent	235	46.5%	270	53.5%	505
Foster Parent	2324	43.4%	3037	56.6%	5361
Grand Total	**2559**		**3307**		**5866**

Notification to caregivers is built into the ACR scheduling process and although a report can be produced as requested, there is no management report that has been put into production so that this data is available on an ongoing basis or at specific points in time. The agency expectation is that caregivers are notified of the ACR no later than twenty-one (21) days prior to the meeting.

LINK report data reflects that 47.1% of the notification letters were generated twenty-one (21) or more days prior to the ACR being held. The letters are generated by the ACR OA as part of the scheduling process, but this relies on the area office social worker having updated address information as well as having identified all of the necessary participants. Once the social worker has completed this, s/he checks of a box in LINK to indicate "all necessary participants have been identified". The OA can then proceed with generating the notification letters. While the data reflects when letters are generated, there is no data point that specific captures whether or not caregivers are successfully notified. It is an expectation that social workers communicate important meeting dates, including court dates and case review dates, to caregivers as they get scheduled. In a foster parent satisfaction survey conducted in 2015, 79.1% of foster parents surveyed indicated they are consistently notified of scheduled court hearings and a higher percentage (87.9%) also reported having an opportunity to be heard in a review or court hearing.

Statement	n/N	Percent
Foster parent being notified consistently of scheduled court hearings	**159/201**	**79.1%**
Foster parent having an opportunity to be heard in review or hearing	**182/207**	**87.9%**

Next, CGS Sec. 46b-129(k) mandates that Judicial provide notice of permanency hearings to parents. Judicial has indicated that they do not currently track notices, but are working on developing, implementing and piloting a data entry program (CPMOH) that will capture information during the

court hearing. As a part of the program, court staff will note who is present during the hearing. That may help identify hearings where foster parents have participated.

Areas Needing Improvement

Timely notification continues to be an area of challenge for the agency. The ACR OA's cannot generate letters until the assigned social workers have identified in LINK which participants must be invited and despite the automated reminders that are generated to social workers well in advance of the meetings, the participants are not always identified timely in LINK. This delays the notifications being generated, which then impacts the timeliness of notification to caregivers. There has also been anecdotal information shared by the OA's indicating that they often receive many letters back due to inaccurate addresses in LINK, which of course impacts the agency's ability to provide timely notification as well as the overall attendance and participation in the ACR meetings. ACR Program Managers continue to message to agency staff about the importance of the accuracy of information in the SACWIS systems and the impact to the case review process and caregiver notification.

C. Quality Assurance System

Item 25: Quality Assurance System

How well is the quality assurance system functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the CFSP are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

Please provide relevant quantitative/qualitative data or information showing that the specified quality assurance requirements are occurring statewide.

State Response:

The Department engages in various activities to ensure the effective functioning of its quality assurance system statewide and across it various regions. A compendium of some of the recurrent qualitative activities in which the Department engages can be accessed via this link.

Each region is assigned a Quality Assurance (QA) Manager. Some regions have also created additional QA Social Work Supervisor and QA Social Worker positions. The Regional QA position count is below:

QI PM	5
QI PD	1
CSC- social security liaison	1
QA/QI SW	7
SW - social security liaison	1
SW - NYTD/social security liaison/ Adol. Spec	1
QI CSC	1
QI SWS	1

These positions engage in a variety of quality functions to support the ongoing review of the efficacy of the local child protection work. They engage in routine data analysis and review, report production, ongoing and ad hoc qualitative case reviews and performance monitoring. For example, these positions

have begun leading monthly quality reviews of the Department's Differential Response System. They and other managers support Enhanced Case Planning, which consists of monthly reviews by Area Office managers of the narrative findings from the Administrative Case Reviews. This information is used to better contextualized the metrics available to Regions regarding the ACR ratings. The Exceptional Case Planning process is used to generate Individualized Support Plans for Social Work Staff based upon observed recurrent areas of challenge.

The Department also convenes a Quality Improvement Council (QIC) that meets twice a month. The QIC is comprised of the Quality Assurance Managers from the DCF Regional Offices, the Director of the Office for Research and Evaluation, the Director of Performance Management, the Director of the Office of Administrative Case Reviews (OACR) and four OACR Managers. Managers from one of the DCF operated facilities, a Manager from the DCF Office of Adolescents and Juvenile Services, a Manager from the Quality Assurance Unit and two representative from the IS SACWIS team also participate.

This body helps to vet qualitative projects in the Department and support uniformity with respect to performance expectations and qualitative review processes. During this Calendar Year, the QIC will be focusing on developing a data governance structure and related policies. They are also be identifying key reports and dashboards for to better support outcome and performance monitoring

Other positions in the Region also complement the work of the QA staff by focusing on the service array and the provision of clinical services. All Region have a Systems Program Director (PD) and a Clinical PD. The Systems PD is responsible for:

> Management and oversight of the regional service system; develops program goals and objectives to conform with department policies, standards and legal matters: assists in directing and coordinating the allocation of staff and resources to maintain service delivery system programs; manages systems/programs to ensure compliance with federal, state and department mandates; develops and monitors budgets for specific programs or administrative area; maintains liaison functions with individuals and organizations that impact on area or program activities; prepares and/or analyzes management reports; performs related duties as required.

The Clinical PD is charged with the following duties:

Directs the Clinical Supports and Services of a Region; develops program goals and objectives to conform with department policies, standards and legal matters; assists in the directing and coordinating of staff and resources to maintain the clinical service delivery system and programs; manages clinical systems and programs to ensure compliance with federal, state and department mandates; acts as the hiring manager for Regional Resource Group (RRG)9; identifies training and developmental needs of clinical staff; supervises and evaluates RRG staff; maintains liaison functions with clinicians and clinically related

9 The RRG are a team of clinical experts housed in the DCF Regions. They consist of Clinicians, Substance Abuse Specialists, Nurses, and Intimate Partner (Domestic) Violence consultants.

organizations that impact on area or program activities; prepares and/or analyzes management reports; reviews work of units for general efficiency and effectiveness with target client population(s); uses data to inform RRG activities and practice; performs related duties as required. Reports to the Regional Administrator, providing leadership, guidance, recommendations, and information for regional clinical services. The Director of Clinical Services also serves as a member of the Regional Executive Leadership team consisting of the Regional Administrator, Systems Program Director, Office Directors, Quality Assurance Program Manager and Quality Improvement Program Manager.

Designs and implements an integrative support service system that provides direct clinical and administrative support services to social work staff. Additionally, the Regional Program Director of Clinical Services will work closely in collaboration with the region's Quality Improvement and Systems Development/Management efforts to assure clinical integration occurs throughout the Region.

As the above indicates, the Department has invested in resources to support implementation and oversight of its quality assurance system at the Regional level. Each Region, DCF Facility and the Administrative Teams, has created Operational Strategies to support achievement of the following standard, agency wide performance expectations:

1. Successfully exit from Juan F. Consent Decree
2. Ensure children reside safely with families whenever possible
3. Achieve racial justice across the DCF system
4. Prepare children and adolescents in care for success
5. Prepare and support the workforce to meet the needs of children and families

These Operational Strategies are presented every quarter to the Commissioner's team. The presentations follow the Results Based Accountability format whereby data and narrative about the efforts to "turn the curve" are discussed. The presentations allow the Regions to share the progress they have made in achieving the identified annual performance expectations. Feedback is provided by the Commissioner's team noting the successes and the areas that appear to be a challenge. Subsequent presentations are used to monitor the progress on all performance expectations, especially any in which concerns have been raised. Notes are taken at these meetings by the Director of Performance Management to ensure appropriate follow-up by the Regions and all other presenting Teams occurs.

In addition, Regional quality assurance work is further aided by assigned Grants and Contract Specialists. These positions provide local fiscal and procurement related support. They are also key partners in supporting the provision of individualized services for the children in the Department's care.

In particular, the Grants and Contracts Specialists are expected to:

> Provide knowledge, expertise, guidance and technical support to all staff on appropriate use of WRAP funds. Perform a wide variety of fiscally focused, specialized tasks in contracts or service acquisition that would lead to efficient and effective procurement to meet the needs of children and families. Assist Social Workers to assess and assemble HUSKY, Contracted, Credentialed and ad hoc services to provide a comprehensive, effective and efficient plan of care. Provide fiscal leadership in making procurement arrangements, identifying service gaps and generating utilization data.

Next, The Department's Office for Research and Evaluation (ORE), which report to DCF's Chief of Quality and Planning, supports myriad qualitative and evaluative within the Department. For example, ORE, through its Risk Management Unit, maintains a database of all significant events. This includes, but is not limited to, data on children and youth in congregate care and Therapeutic Foster Care who may have had calls to the police and arrests, emergency services for medical or psychiatric reasons, single and group runaways, calls for EMPS, youth's self-injurious behavior, and adverse events in a facility. These data points are available and used by the Department to comprehensively assess the functioning and performance of service types that are expected to safely and appropriately care for a child/youth in a congregate care or private foster care setting.

For example, last year ORE engaged in a foster care satisfaction survey process. A random sample of children 8 years old and older who were placed in a foster home (DCF Core, Relative/Kin or Therapeutic Foster Care) were invited to participate in a cross-sectional study. Data were collected through face-to-face interviews with 225 children and 221 caregivers. Foster youth 13 years and older were also asked to complete a supplemental self-administered questionnaire to assess their pro-social and potentially detrimental behaviors. Descriptive statistics were used to examine the level of quality and satisfaction.

The preliminary results of the data collected from the survey have been shared with the Department's leadership team, the Communities of Practice (COP)10, and are posted on the DCF external facing webpage. These data are supporting the agency's examination of the level of quality and satisfaction of foster home placements, as well as associated factors among foster children and their caregivers.

Specifically, one of the findings from the report is that over a quarter of the youth survey indicated that they did not find the Administrative Care Review (ACR) meetings to be beneficial. Based on that data, the ACR leadership team is developing a plan to outreach to youth about their ACR experiences, with an eye towards making it more meaningful and useful to them.

ORE staff also conduct case reviews on a quarterly basis in order to determine compliance with the Federal Juan F. Exit Outcome. The report is completed and submitted quarterly to the Office of the Court Monitor based on a calendar year. These reviews occur to observe the Department's case practice regarding placing siblings together and any barriers. The standard to be met is 95% of children in care with siblings in care are to be placed with all of their siblings unless there is a clinical reason why they are placed separately. They ae also reviewing the achievement of measures of discharge. The standard is that at least 85% of youth, 18 and over who are discharged from the Department's care meet at least one of the 6 measures.

While ORE continues to conduce case review on both these measures, they have been deemed to be "pre-certified" by the Court Monitor. This means that the Department has sustained compliance as required by the Revised Exit Plan for at least two consecutive quarters (6 months). The purpose of the Pre-

10 These are "affinity" groups that meet at least monthly to focus on distinct areas of the Department. Some of the Communities of Practice (COP) include: Early Childhood, Intake, Foster Care, Nursing, Fatherhood Engagement.

Certification Review is to recognize DCF's sustained improved performance. Currently, 15 out of 22 of the Outcome Measures have been certified. They are as follows:

OM 4: Search for Relatives	If a child(ren) must be removed from his or her home, DCF shall conduct and document a search for maternal and paternal relatives, extended formal or informal networks, friends of the child or family, former foster parents, or other persons known to the child. The search period shall extend through the first six (6) months following removal from home. The search shall be conducted and documented in at least 85.0% of the cases.
OM 5: Repeat Maltreatment of Children	No more than 7% of the children who are victims of substantiated maltreatment during any six-month period shall be the substantiated victims of additional maltreatment during any subsequent six-month period. This outcome shall begin to be measured within the six-month period beginning January 1, 2004.
OM6: Maltreatment of Children in Out-of-Home Care	No more than 2% of the children in out of home care on or after January 1, 2004 shall be the victims of substantiated maltreatment by substitute caregivers while in out of home care.
OM 7: Reunification	At least 60% of the children, who are reunified with their parents or guardians, shall be reunified within 12 months of their most recent removal from home.
OM 8: Adoption	At least 32% of the children who are adopted shall have their adoptions finalized within 24 months of the child's most recent removal from his/her home.
OM 9: Transfer of Guardianship	At least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of the child's most recent removal from his/her home.
OM 10: Sibling Placement	At least 95% of siblings currently in or entering out-of-home placement shall be placed together unless there are documented clinical reasons for separate placements. Excludes Voluntary cases and children for whom TPR has been granted.
OM 11: Re-Entry into DCF Care	Of the children who enter DCF custody, seven (7) percent or fewer shall have re-entered care within 12 months of the prior out-of-home placement.
OM 12: Multiple Placements	Beginning on January 1, 2004, at least 85% of the children in DCF custody shall experience no more than three (3) placements during any twelve month period.
OM 14: Placement within Licensed Capacity	At least 96% of all children placed in foster homes shall be in foster homes operating within their licensed capacity, except when necessary to accommodate sibling groups.

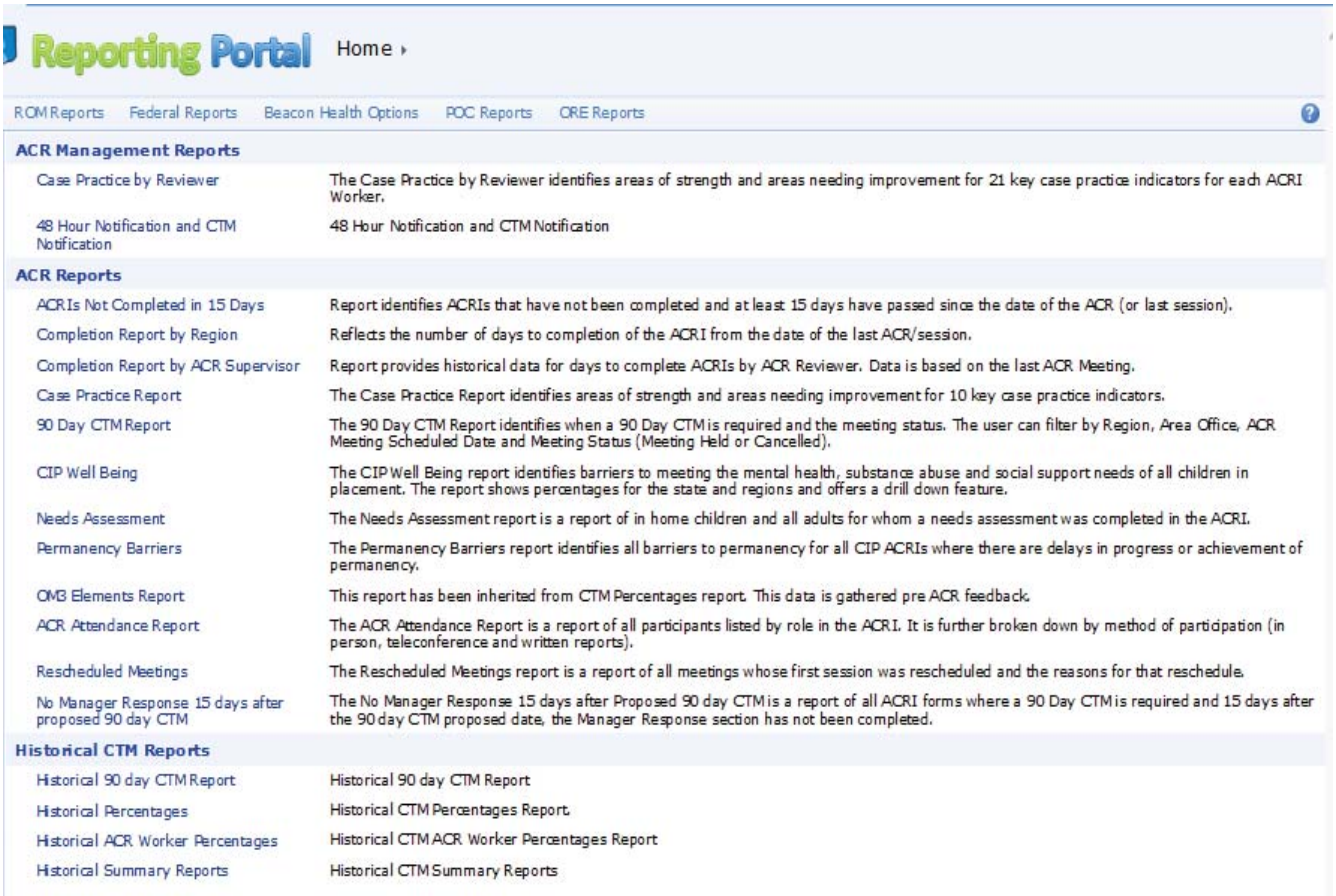
OM 16: Worker/ Child Visitation (Child in Placement)	DCF shall visit at least 85% of all out-of-home children at least once a month, except for probate, interstate, or voluntary cases. All children must be seen by their DCF Social Worker at least quarterly.
OM 17: Worker-Child Visitation (In-Home)	DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases. Definitions and Clarifications: 1. Twice monthly visitation must be documented with each active child participant in the case. Visitation occurring in the home, school or other community setting will be considered for Outcome Measure 17.
OM 19: Reduction in the Number of Children Placed in Residential Care	The number of children placed in privately operated residential treatment care shall not exceed 11% of the total number of children in DCF out-of-home care. The circumstances of all children in-state and out-of-state residential facilities shall be assessed after the Court's approval of this Exit Plan on a child specific basis to determine if their needs can be met in a less restrictive setting.
OM 20: Discharge Measures	At least 85.0% of all children age 18 or older shall have achieved one or more of the following prior to discharge from DCF custody: (a) Graduation from High School; (b) Acquisition of GED; (c) Enrollment in or completion of college or other post secondary training program full-time; (d) Enrollment in college or other post secondary training program part-time with part-time employment; (e) Full-time employment; (f) Enlistment full-time member of the military.
OM 21: Discharge of Mentally Ill or Developmentally Disabled Youth	DCF shall submit a written discharge plan to either/or DMHAS or DDS for all children who are mentally ill or developmentally delayed and require adult services.
OM22: Multi-disciplinary Exams	At least 85% of the children entering the custody of DCF for the first time shall have an MDE conducted within 30 days of placement.

The above are a few limited examples of the Statewide and Regional informing quality assurance work conducted by ORE. For a more detailed accounting of ORE's various activities, please access the following link and view pages 4 – 41.

The Department's ACR process contributes greatly to DCF's quality assurance system. Congruent with federal requirements, administrative case reviews occur every six months for children in foster care. Last year, the Department conducted over 13,000 ACR meetings. DCF uses a cadre of Social Work Supervision level staff assigned specific to conducting ACRs. They use a comprehensive, 37 pages, electronic, Administrative Case Review tool whereby a variety of process and qualitative items related to safety, permanency, health and well-being are rated. This tool, referred to as the Administrative Case Review Instrument (ACRi) is based on the CFSR Round Two items. Some of the areas assessed through the Department's ACR process are as follows:

- Quality of the case plan
- Frequency and quality of visits
- Appropriateness of services to strengthen education/development in place
- Is the child involved/engaged in services to address behavioral health issues or strengthen coping skills? (Including medication management)
- Is the child involved/engaged in services to address physical health limitations/disabilities issues.
- Have frequent quality contacts been made with service providers actively involved with the child in the last six months.
- If the permanency goal is Reunification, have there been timely and accurate SDM Assessments (FSNA/Reunification Assessment/Reassessments) at 90-day intervals as required by policy?
- Did the Department conduct initial and ongoing safety and risk assessments. If concerns were noted, were they adequately and appropriately addressed by the Department.
- If a safety plan was developed, did the Department continually monitor and update the safety plan, including encouraging family engagement in services designed to promote achievement of the goals of the safety plan.

There are a variety of Office of Administrative Case Review (OACR) reports available to track and monitor agency performance with respect to various case plan elements. A screenshot of the ACR reports' portal is below:



Data from the ACR Case Practice Report is below. The chart shows the top ten case practice data elements. This data comes from the ACR Instrument SharePoint portal. There are 30 additional elements that can be included in the report using filters. Regional views of these data are also available.

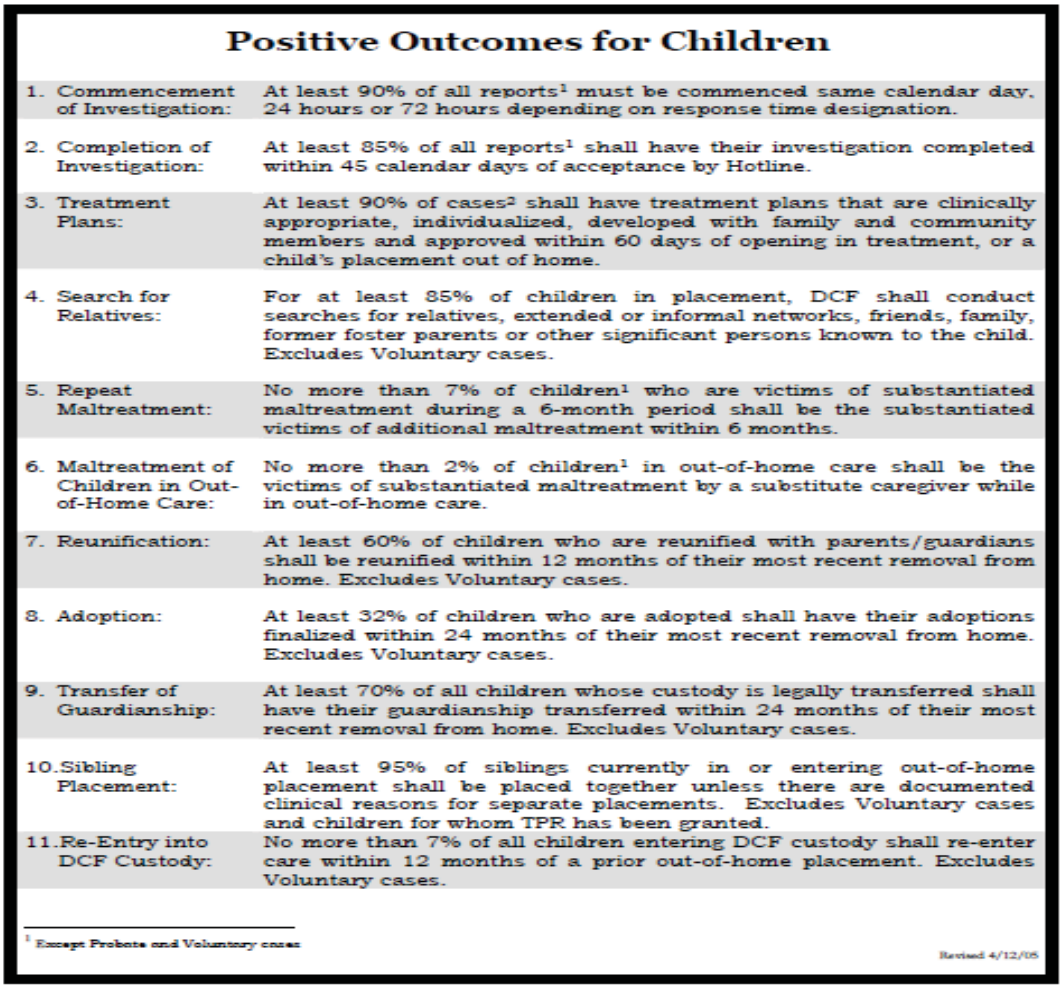
Sl.No	Measure	Statewide		
		January, 2016	February, 2016	March, 2016
		Strength	Strength	Strength
		%	%	%
1	Visitation with Child and Parents	65%	71%	72%
10	Risk & Safety - Child in Placement	91%	91%	92%
12	Continuity of Relationship - Child w / Parents	91%	92%	91%
15	Collateral Contact - Parents	79%	81%	82%
19	Parent Needs	74%	77%	81%
24	Physical health care - Child	86%	82%	90%
25	SA/Social Support/MH - Child	88%	88%	89%
38	Transition Plan	96%	91%	91%
39	Permanency	91%	90%	87%
45	Case Plan Assessment	69%	72%	68%

As the data reveal, there are a number of measures in which the Department is doing well. Others, such as Visitation, Case Plan Assessment, and Parent Needs are ones in which improvement could occur. The Department has just begun to implement an Exceptional Case Planning (ECP) practice as noted earlier.

The ECP approach requires Area Office Managers to regularly review the findings in the ACRi for their staff to assess case practice strengths and systemic areas needing improvement. Individual Support Plans are developed for staff whose performance on the ACR and individual elements is not satisfactory, particularly as it relates to areas of case planning and client's needs being met.

In the Norwich DCF Office for example, CPS Managers read approximately an average of 105 ACRis per month. This translates into roughly 75% of all the ACRis generated per month being reviewed by one of the CPS Managers in the Norwich Office. The volumes of ACRi reviews across Area Offices varies. Some have a minimum threshold of 5 ACRis per month, per manager. The occurrence of ECP is an area that is standardly discussed during the presentation of Region's Operational Strategies.

The Department also monitors the qualitative of services through standard Outcome Measures under the Juan F. Consent Decree. There are 22 OMs upon which the Department and the Court Monitor evaluate on a regular basis. They are as follows:



Positive Outcomes for Children

1. Commencement of Investigation:	At least 90% of all reports[1] must be commenced same calendar day, 24 hours or 72 hours depending on response time designation.
2. Completion of Investigation:	At least 85% of all reports[1] shall have their investigation completed within 45 calendar days of acceptance by Hotline.
3. Treatment Plans:	At least 90% of cases[2] shall have treatment plans that are clinically appropriate, individualized, developed with family and community members and approved within 60 days of opening in treatment, or a child's placement out of home.
4. Search for Relatives:	For at least 85% of children in placement, DCF shall conduct searches for relatives, extended or informal networks, friends, family, former foster parents or other significant persons known to the child. Excludes Voluntary cases.
5. Repeat Maltreatment:	No more than 7% of children[1] who are victims of substantiated maltreatment during a 6-month period shall be the substantiated victims of additional maltreatment within 6 months.
6. Maltreatment of Children in Out-of-Home Care:	No more than 2% of children[1] in out-of-home care shall be the victims of substantiated maltreatment by a substitute caregiver while in out-of-home care.
7. Reunification:	At least 60% of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home. Excludes Voluntary cases.
8. Adoption:	At least 32% of children who are adopted shall have their adoptions finalized within 24 months of their most recent removal from home. Excludes Voluntary cases.
9. Transfer of Guardianship:	At least 70% of all children whose custody is legally transferred shall have their guardianship transferred within 24 months of their most recent removal from home. Excludes Voluntary cases.
10. Sibling Placement:	At least 95% of siblings currently in or entering out-of-home placement shall be placed together unless there are documented clinical reasons for separate placements. Excludes Voluntary cases and children for whom TPR has been granted.
11. Re-Entry into DCF Custody:	No more than 7% of all children entering DCF custody shall re-enter care within 12 months of a prior out-of-home placement. Excludes Voluntary cases.

[1] Except Probate and Voluntary cases

Revised 4/12/05

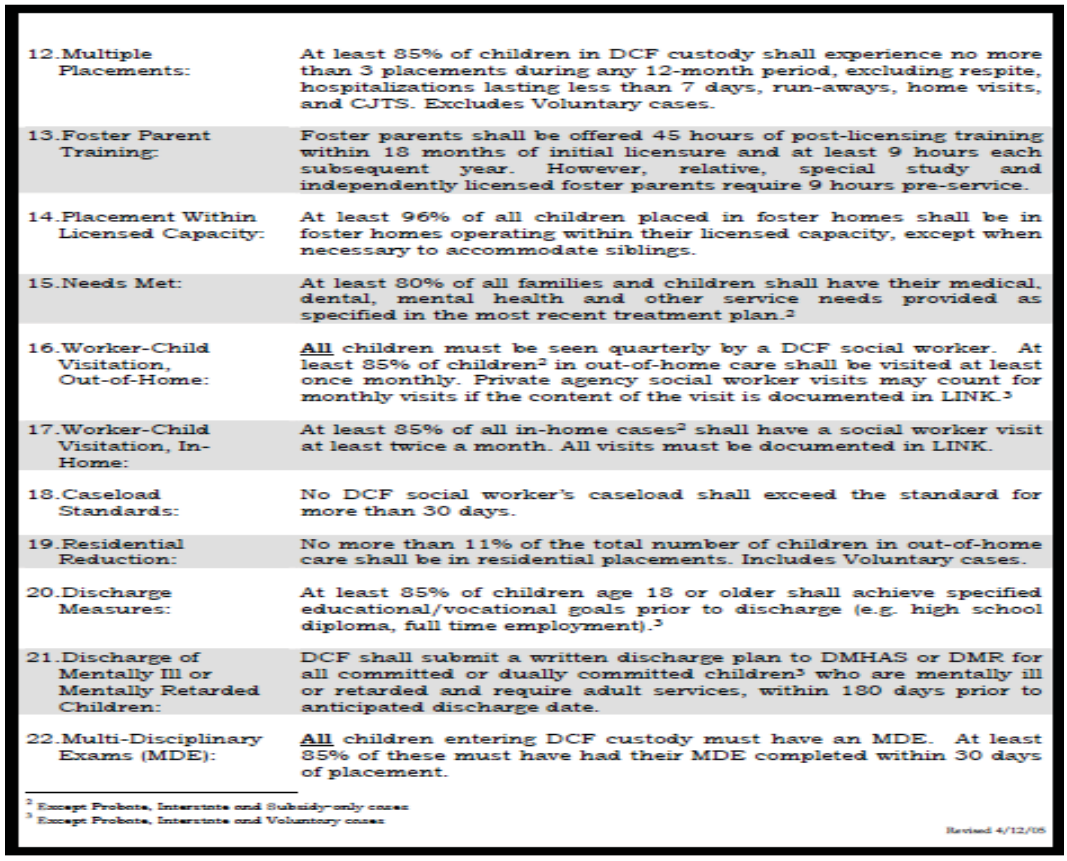
Copies of the Court Monitor's reports and the Department's most recent achievements on the above outcome measures can be accessed via this link.

Three of those measures are specifically being focused on under the Department's Performance Expectations. They are as follows:

- Outcome Measure 3: Treatment Plans: In at least 90% of the cases, except probate, interstate, voluntary and subsidy only cases, clinically appropriate individualized family and child specific treatment plans shall be developed in conjunction with parents, children, providers and others involved with the case and approved by a DCF supervisor within 60 days of case opening in a treatment unit, or a child's placement out-of-home, whichever comes sooner, and for each six (6) month period thereafter.

- Outcome Measure 15: Children's Needs Met: At least 80% of all families and children shall have all their medical, dental, mental health and other service needs provided as specified in their most recently approved clinically appropriate treatment plan.

- Outcome Measure 17: Worker-Child Visitation (In-Home)**:** DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases.



12. Multiple Placements:	At least 85% of children in DCF custody shall experience no more than 3 placements during any 12-month period, excluding respite, hospitalizations lasting less than 7 days, run-aways, home visits, and CJTS. Excludes Voluntary cases.
13. Foster Parent Training:	Foster parents shall be offered 45 hours of post-licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. However, relative, special study and independently licensed foster parents require 9 hours pre-service.
14. Placement Within Licensed Capacity:	At least 96% of all children placed in foster homes shall be in foster homes operating within their licensed capacity, except when necessary to accommodate siblings.
15. Needs Met:	At least 80% of all families and children shall have their medical, dental, mental health and other service needs provided as specified in the most recent treatment plan.[2]
16. Worker-Child Visitation, Out-of-Home:	**All** children must be seen quarterly by a DCF social worker. At least 85% of children[2] in out-of-home care shall be visited at least once monthly. Private agency social worker visits may count for monthly visits if the content of the visit is documented in LINK.[3]
17. Worker-Child Visitation, In-Home:	At least 85% of all in-home cases[2] shall have a social worker visit at least twice a month. All visits must be documented in LINK.
18. Caseload Standards:	No DCF social worker's caseload shall exceed the standard for more than 30 days.
19. Residential Reduction:	No more than 11% of the total number of children in out-of-home care shall be in residential placements. Includes Voluntary cases.
20. Discharge Measures:	At least 85% of children age 18 or older shall achieve specified educational/vocational goals prior to discharge (e.g. high school diploma, full time employment).[3]
21. Discharge of Mentally Ill or Mentally Retarded Children:	DCF shall submit a written discharge plan to DMHAS or DMR for all committed or dually committed children[3] who are mentally ill or retarded and require adult services, within 180 days prior to anticipated discharge date.
22. Multi-Disciplinary Exams (MDE):	**All** children entering DCF custody must have an MDE. At least 85% of these must have had their MDE completed within 30 days of placement.

[2] Except Probate, Interstate and Subsidy-only cases
[3] Except Probate, Interstate and Voluntary cases

Revised 4/12/05

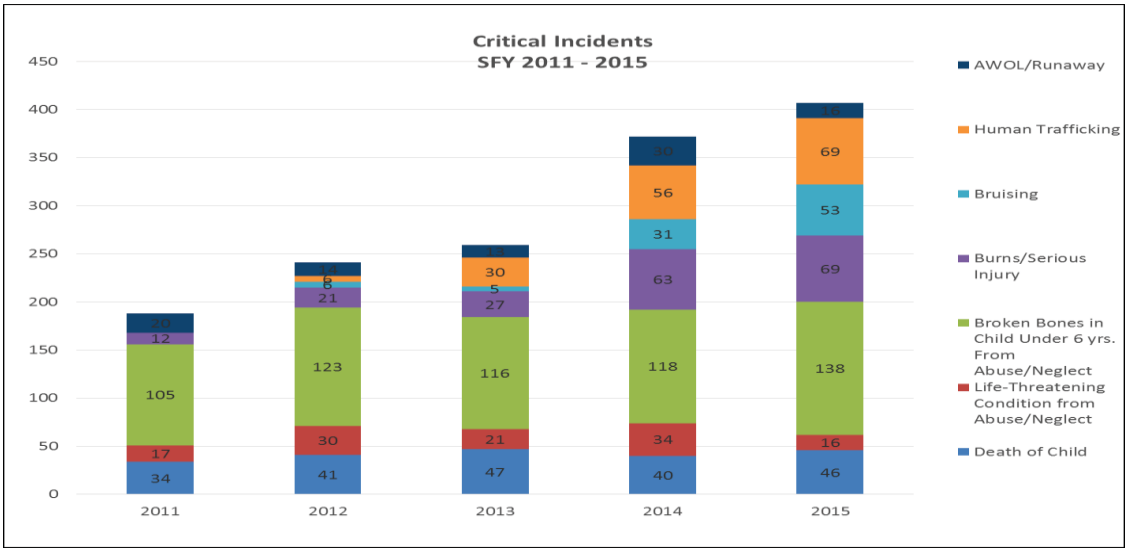
Data on these Outcome Measures for 3rd Quarter 2015 reveal the need for improvement in the areas of treatment planning and needs met:

Positive Outcomes For Children- Statewide		
Measure	Measure	Q3 2015
3: Treatment Plans	>=90%	53.7%
15: Children's Needs Met	>=80%	57.4%
17: Worker-Child Visitation (In-Home)	>=85%	87.5%

The introduction of Exceptional Case Planning and the implementation of Regional Operational Strategies are thought to be solid mechanisms to aid with producing better results with respect to case planning, needs being met and sufficient, quality visitation occurring.

The Department also maintains a Risk Management Database to monitor significant events (e.g., arrests, AWOLs, and run-aways) and critical injuries[11] that involve the health and safety of DCF involved children. Information on such events is received from the DCF Careline, our centralized intake, and DCF contracted providers (e.g., congregate care and Therapeutic Foster Care). The Department maintains a repository to monitor Emergency Safety Interventions such as restraints and seclusions. These data are received from DCF owned Facilities (e.g., Connecticut Juvenile Training School) and DCF contracted providers.

Some critical incident data from SFY 2011- 2015 are below. While the data may appear to suggest increased occurrence of critical incidents and injuries over the years, the Department thinks the data is reflective of better surveillance and collection. In particular, within the last two years, Connecticut legislation has been passed to stiffen the penalties for failure to report suspected abuse and neglect. Related, the Department has partnered with the Connecticut Hospital Association to support outreach to health care providers regarding reporting of abuse and neglect. We also have a contract with Yale University and the Connecticut Children's Medical Center to support consultation to our Careline staff regarding calls that may involve suspected physical abuse. Connecticut is also a national leader with respect to better serving youth who are victims of minor domestic sex trafficking. These foci are thought to be contributing to more comprehensive and accurate data collection concerning critical injuries and events involving Connecticut children and youth.

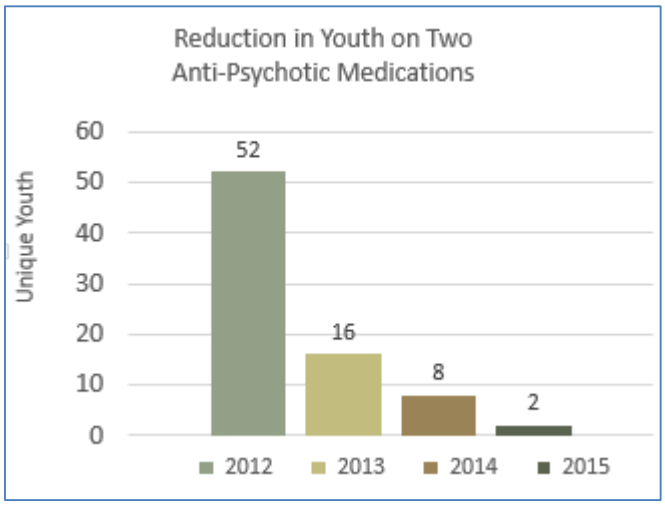


Data regarding medication errors and prescription of psychotropic medications are also maintained by the Department. The below are some data from the CY 2015 3rd and 4th quarter Operational Strategies presentation by DCF's Centralized Medication Consent Unit (CMCU).

11 Critical injury and fatality data reflect any child or youth reported to the Department. These data do include both DCF and Non-DCF involved children.

January 1 – June 30 2015

# Total Requests	1076
# Unique Youth	611
# Unique Youth ≥ 4 Psychotropic meds	53



Since the conception of CMCU in 2007, the use of concurrent anti-psychotic medications has been significantly reduced. There have not been any youth on three or more anti-psychotic medications, and the use of two has been reduced for all DCF youth on psychotropic medications.

In addition, the Department employs a variety of means to identify the strengths and needs of its service delivery system. For example, the Department employs a dedicated Program Director level position that leads DCF's RBA and performance expectation activities under the Office of Performance Management. This manager works with DCF's Contracts Division, ORE and Program Development and Oversight Coordinators (PDOCs) who are assigned to oversee the Department's contracted services.

This position has worked to support all DCF contracts having outcome measures. As such, all DCF Purchase of Services (POS) contracts contain outcome measures. Nearly 90% of our POS contracts contain measures that conform to the Results Based Accountability (RBA) format. Some also include additional process indicators (e.g., at least 80% of all mobile responses will take place in 45 minutes or less from the end of the triage call; 90% of families/ caregivers will complete the Ohio Scales at Intake, etc.).

An example of how POS contract measures have been conceptualized and constructed within a RBA framework is to the right:

Service Type	How much did we do?	How well did we do it?	Is anyone better off?
Behavioral Health Services	Number of clients served annually	•Percentage of children, youth and families served who successfully complete treatment •Percentage of families who complete treatment successfully and have a service length of stay between 120-160 days. •Percentage of children/youth and families served who are successfully linked to community based services and/or pro-social supports •Percentage of children/youth served who avoid the need for psychiatric hospitalization during the course of services •Percentage of children/youth who avoid an out-of-home placement during the course of services Percentage of families and caregivers completing the Ohio Scales at intake and at discharge	• Percentage of participants who demonstrate increased functioning • Percentage of participants who • demonstrate decrease in problem severity • Percent of clients who met treatment goals

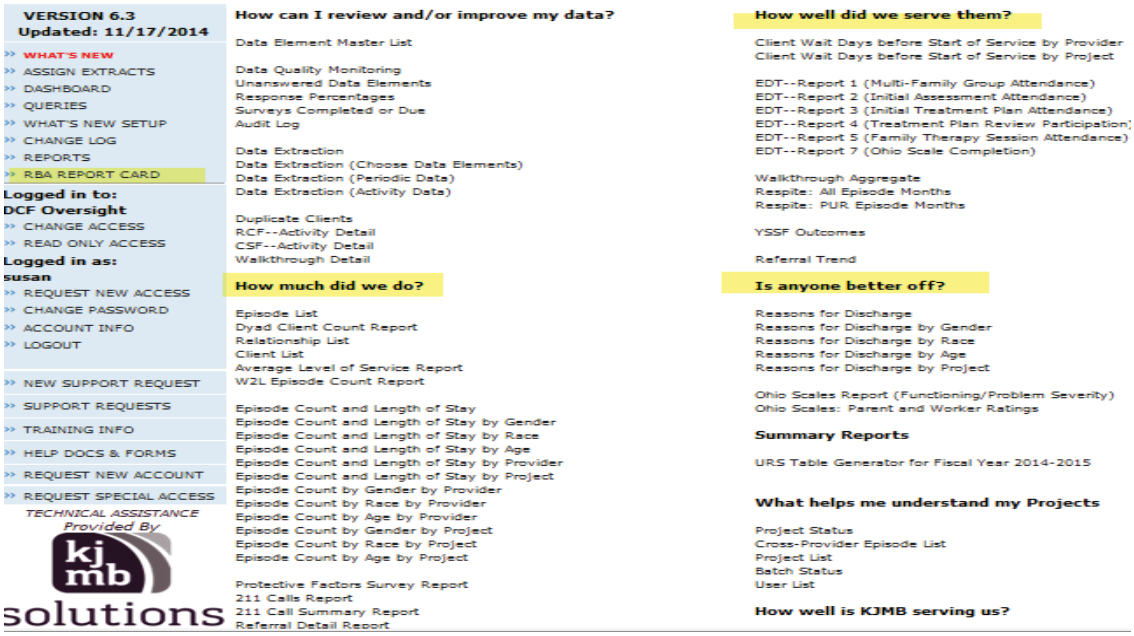
A guidance has also been created to direct the development of performance measures for DCF contracted services. Practice Guides have also been created for some service types to concretize service and performance expectations that are outlined in the contracts.

Next, the Department launched the Provider Information Exchange (PIE) (formerly known as Program and Services Data Collection and Reporting (PSDCRS)) data in 2009. PIE is a real-time, client level reporting system that allows for program and performance monitoring of DCF contracted services. The system provides users with automated Alerts and/or Reminders for work that needs to get done, as well as a program-specific Data Dashboard, which is updated daily, displaying a set of common reports on a single page.

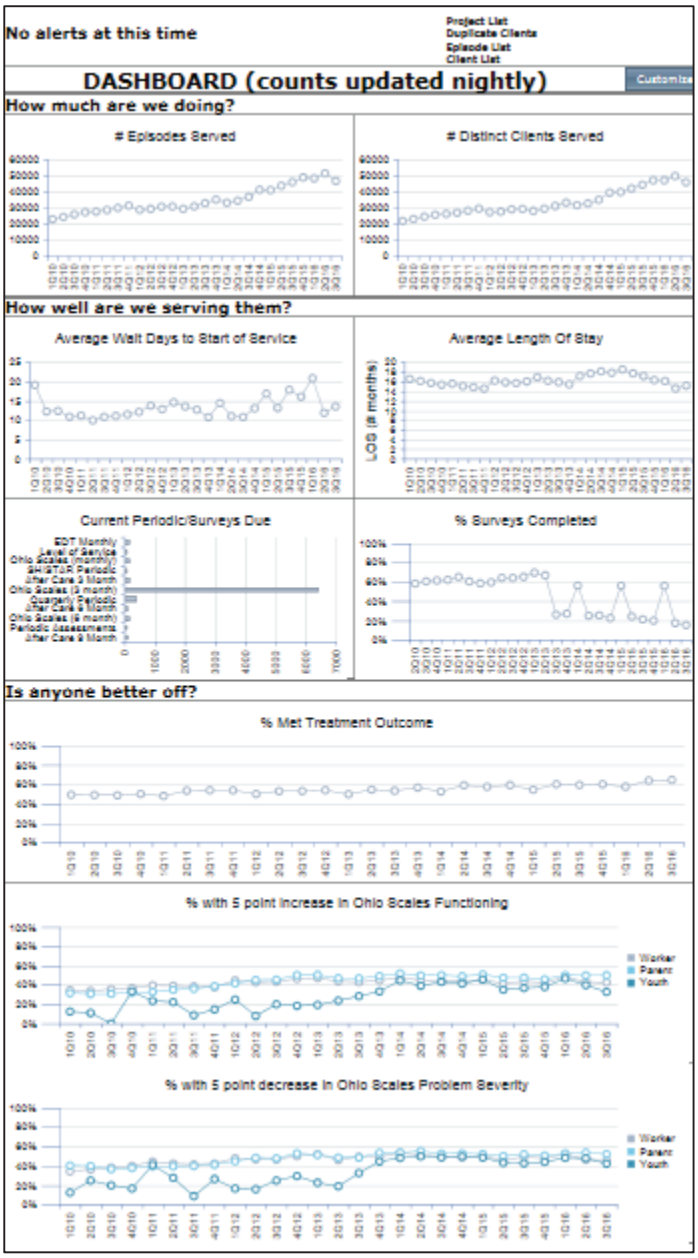
There are also client-specific and general reports that provide information that help to answer the following questions:

- How can I view/improve my data?
- How much did we do?
- How well did we serve them?
- Is anyone better off?
- What helps me understand my Projects?
- How Well is KJMB serving us?

Reports, dashboards, and data extracts (i.e., access to raw data) from PIE allow the assigned PDOCs (and Contracted Providers) to evaluate the quality and efficacy of DCF funded services. PIE data reports are categorized within a RBA framework to allow PDOCs, Systems Program Directors (i.e., managers in each region who oversee the local DCF service array), and contracted providers to understand and view service provision through the lens of *How Much*, *How Well* and *Is Any One Better Off*? The screen shot above shows the reports layout within PIE.



The Department will be expanding the array of reports available to DCF Staff and providers. In particular, a fully automated Reports Based Accountability (RBA) Report Card is in development. A beta test version of that Report Card currently exists. It automatically populates the Report Card with How Much¸ How Well and Better Off data and trends that information to display improvement, a decline, or no change. DCF contract leads will have the ability to put in the accompanying RBA Report Card narrative.



The side screenshot shows the dashboards that are immediately present upon login into PIE. This data collection system contains over 900 data elements. It collects baseline client start of service data and concluding discharge data.

Some programs in PIE also collect periodic data (e.g., client data updates ever quarter or six months). Activities or event level data is also collected for select service types in PIE. This level of data allows for the Department to assess information about key service provision (e.g., face to face contact with a client, duration of visits, location of services, participants, etc.). PIE collects post-discharge/aftercare data for some services. An example of aftercare data would be evidence of supporting transition and monitoring stability of a step down from Therapeutic Foster Care to core foster, relative placement or reunification.

PIE also collects data on outcomes using a variety of assessment tools. Some behavioral health programs use the Ohio Scales, which is a normed, clinical assessment instrument, to monitor child functioning and improvements. Some substance abuse programs use the Global Appraisal of Individual Needs (GAIN). The North Carolina Family Assessment Survey (NCFAS), Ages and Stages Questionnaire and/or the Protective Factors Survey are used by other DCF funded programs to determine client improvements pertaining to the area of family support early childhood services.

The federally promulgated Youth Satisfaction Service for Families (YSS-F) has also been built into PIE. DCF funded behavioral health service providers are required to complete the YSS-F with the families they are serving, and input the results into PIE. The YSS-F data are submitted to the federal government annually to support compliance with the Mental Health Block Grant.

Last calendar year, January 1, 2015 – December 31, 2015, 5,215 Youth Satisfaction Surveys for Families were completed. This is about 19% of the 30,203 clients identified by PIE as being served in various DCF contracted services. Results from the YSS-F are below. As these data reveal, in all domains collected, the majority of responses were positive (e.g., "Agree" or "Strong Agree."). In particular, out of a Likert score of 1- 5[12], the mean scores for the domains of "Access," "Satisfaction," "Outcomes," "Treatment Planning," "Cultural," "Social" and "Functioning," ranged from 3.96 – 4.65.

YSSF Outcomes -- Selected Filters

Logged in to: DCF Oversight

Date run: 03/08/2016 07:25:00 PM ET

Episodes Ending between : 01/01/2015 to 12/31/2015

Total Responses Required	30203

Data Element	Total Responses	Valid Response %	% English	%Spanish
LanguageVersionQuestionDischarge	5215	17%	93%	7%

YSS-F Domains: Calculated Variable	Total Responses*	Valid Response %	Mean*	Standard Deviation
YSSFAccess	5719	19%	4.56	.66
YSSFSatisfaction	5736	19%	4.44	.66
YSSFOutcomes	5720	19%	3.96	.84
YSSFTreatmentPlanning	5731	19%	4.45	.65
YSSFCultural	5710	19%	4.65	.58
YSSFSocial	5702	19%	4.3	.68
YSSFFunctioning	5721	19%	3.97	.83

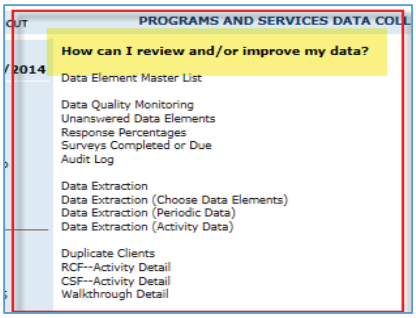
	Data Element	Total Responses	Valid Response %	1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree	Mean	Standard Deviation
	YSS-F Access Domain									
	YSSFLocationConvenient	5724	19%	1%	1%	3%	30%	65%	4.6	.72
	YSSFServiceTimesConvenient	5732	19%	1%	1%	3%	32%	63%	4.5	.72
	YSS-F Cultural Domain									
	YSSFStaffTreatedMeWithRespect	5735	19%	1%	%	1%	24%	74%	4.7	.63
	YSSFStaffRespectedBeliefs	5697	19%	1%	%	3%	26%	70%	4.6	.65
	YSSFStaffSpokeInWayUnderstood	5707	19%	1%	%	1%	26%	71%	4.7	.62
	YSSFStaffSensitiveToCulturalBackground	5689	19%	1%	%	3%	28%	68%	4.6	.68
	YSS-F Functioning & Outcomes Domains*									
F	YSSFResultofServicesChildBetterAble	5697	19%	2%	5%	17%	45%	31%	4	.92
O/F	YSSFResultOfServicesChildHandlesDailyLife	5714	19%	2%	5%	17%	41%	35%	4	.95
O/F	YSSFResultOfServicesChildGetsAlongFamily	5711	19%	2%	6%	17%	43%	32%	4	.95

[12] *1-Strongly Disagree □ 2-Disagree □ 3-Undecided □ 4-Agree □ 5-Strongly Agree*

O/F	YSSFResultofServicesChildGetsAlongFriends	5708	19%	1%	5%	17%	44%	33%	4	.91
O/F	YSSFResultofServicesChildBetterSchool	5690	19%	3%	7%	18%	38%	35%	4	1.02
O/F	YSSFResultofServicesChildBetterCopes	5712	19%	2%	7%	19%	43%	28%	3.9	.98
O	YSSFResultofServicesParentHappyWithFamily	5702	19%	3%	8%	17%	42%	30%	3.9	1.02
	YSS-F Satisfaction Domain									
	YSSFOverallSatisfied	5734	19%	2%	1%	4%	33%	60%	4.5	.78
	YSSFPeopleHelpedNoMatterWhat	5725	19%	1%	1%	3%	29%	67%	4.6	.72
	YSSFChildHadSomeoneToTalkTo	5716	19%	1%	1%	5%	34%	59%	4.5	.75
	YSSFServicesReceivedRightForUs	5729	19%	1%	2%	8%	34%	56%	4.4	.8
	YSSFFamilyGotHelpWantedForChild	5728	19%	1%	2%	8%	35%	53%	4.4	.82
	YSSFFamilyGotAsMuchHelpNeeded	5729	19%	1%	3%	11%	34%	51%	4.3	.88
	YSS-F Social Domain									
	YSSFResultofServicesParentKnowsPeopleListen	5697	19%	1%	1%	7%	46%	44%	4.3	.75
	YSSFResultofServicesParentKnowsPeopleComfortable	5706	19%	1%	1%	6%	44%	49%	4.4	.73
	YSSFResultofServicesParentHasCrisisSupport	5701	19%	1%	2%	9%	43%	44%	4.3	.83
	YSSFResultofServicesParentHasPeopleEnjoyable	5692	19%	1%	2%	13%	44%	40%	4.2	.82
	YSS-F Treatment Domain									
	YSSFHelpedChooseServices	5728	19%	1%	2%	5%	41%	51%	4.4	.8
	YSSFHelpedChooseTreatmentGoals	5721	19%	1%	1%	4%	40%	54%	4.4	.72
	YSSFParticipatedinChildTreatment	5719	19%	1%	1%	3%	34%	62%	4.5	.71

Table Notes:
1. The mean of the calculated Domain variables includes ONLY those where the domain requirements were met (see training doc "Extracts: The Calculated YSS-F Variables" outlining this)
2. The Functioning and Outcomes domains share some data elements. These are indicated by "F" for Functioning only, "O" for Outcomes only, and "O/F" for the shared elements.
3. The numerator for the percentages of each individual element is the actual 'Total Responses' for each element, and the denominator is the 'Total Responses Required' (listed once at the top of the report)

As a means to ensure the quality of PIE data, a number of processes and reports have been created to aid with oversight. A screenshot of those is to the side. For example, PIE contains a "Data Quality Monitoring" report. This allows for the Department and providers inputting data to review the missing data for any element in the system. A screenshot of that report is below:



Data Quality Monitoring

Please enter the filters (most filters are optional) then press Go. Show Filters

Export to Excel (only data on the page will export; only last run report will export)

Data Quality Monitoring -- Selected Filters

Logged in to: DCF Oversight
Date run: 03/08/2016 06:51:32 PM ET
Program: (CC) Care Coordination
Options: Include Evaluation Only, Include Crisis Response Only
Data Group: Discharge Survey
Data Element: SuspendedSchoolDuring
Show Detail: No

Data Element:	SuspendedSchoolDuring
Question:	During this episode of care, was the child suspended or expelled from school

Answer	Answer Frequency	Total %	Required %	Answered %
Yes	755	15%	16%	17%
No	3680	75%	79%	83%
Unanswered, required	244	5%	5%	-
Unanswered	198	4%	-	-
Total Number of Episodes	**4877**	**4877**	**4679**	**4435**

Related Data Elements:
SuspendedSchoolPrior SuspendedSchoolPeriodic IsEvaluationOnly SchoolAttendanceDuring IsCrisisResponseOnly

Table Notes:
a. Client type data, which is generally not considered part of a specific episode, will still be pulled into the report when using the Episode-related Date filters and, like any episode-related data elements, will be displayed for each episod a client has within the filter selections made when running the report.
b. Data that is age-related (i.e. Ohio Scales and PSI/ASI) will show up as 'Unanswered, required' even if the reason for it being blank is the child/client's age being outside the limits. To filter based on age, use the new Age at Intake filter.
c. The "TOTAL" is a count of all instances of the unit, such as client or episode. The "Answer Frequency" column shows the # of responses for any answer category. For "Choose One Answer" data elements, the sum of the Answer Frequency column will equal the TOTAL. For "Choose All That Apply" data elements, the sum of the Answer Frequency column will likely be more than the TOTAL. This will happen when multiple answer choices are selected. Similarly, the sum of the percentages displayed will likely total greater than 100% because the TOTAL is used as the denominator when calculating the percentage. This type of analysis is referred to as "Multiple Response" reporting in statistical packages such as SPSS.
d. This report looks at several different factors to determine if a question that does not have an answer should be counted as "Unanswered" or "Unanswered, Required". The "Unanswered" count represents questions that may not have been required at the time of entry, due to Conditional Logic, Client Age, Data Element Start Date, Data Element End Date, Project Start Date, Episode Start Date, etc... The "Unanswered, Required" count represents questions that mos likely should have an answer, according to all information in the database and in the episode itself. However, when it is hard to determine based on all of the factors, the report errs on the side of counting questions as "Unanswered" rather than "Unanswered, Required". Data Elements are established for each program, and are listed in the Master Data Element List found on the Help Docs & Forms page of PSDCRS. Please review that document for more information about data elements in a given program, especially the Start Date and End Date of data elements per program.

Based upon the sample report above, it indicates that for the variable assessing the number of days a youth was suspended from school, required data was missing in only 244 instances out of 4,679 applicable records. Thus, 95% of expected data has been provided for this variable.

Next, a comprehensive "customer support" feature has been built into PIE. Users are able to login into the system and create a "ticket" to receive assistance regarding any variety of issues, including data fixes. A sample of this support feature is below:

Support Ticket Detail

Please enter the filters (most filters are optional) then press Go. Show Filters

Export to Excel (only data on the page will export; only last run report will export)

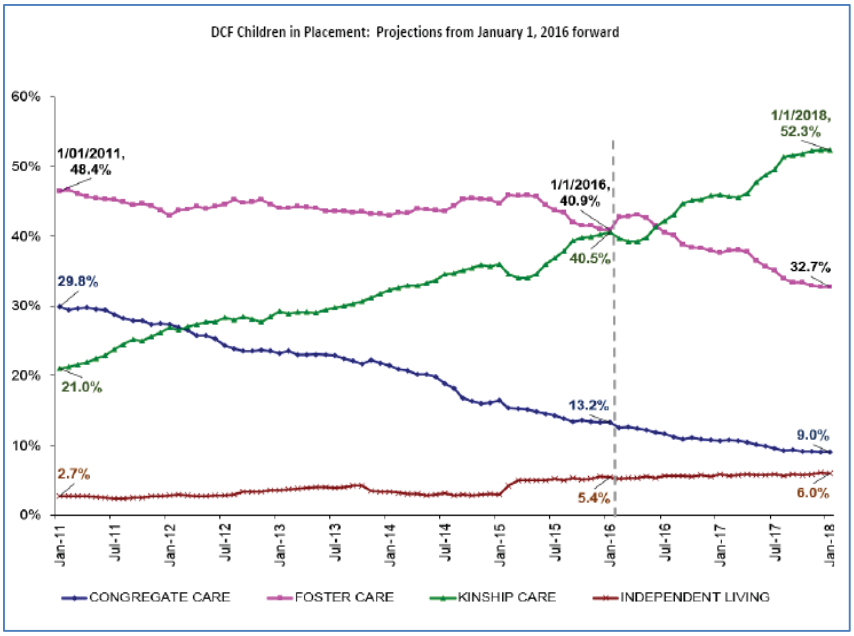
Support Ticket Detail -- Selected Filters

Logged in to: DCF Oversight
Date run: 03/08/2016 07:11:41 PM ET
Program: (TFC) Therapeutic Foster Care
Ticket Open Date: 10/01/2015 to 12/31/2015

ID	Requested By	Request Date/Time	Category	Data Fix Reason	Assigned To KJMB	Assigned To Lead	Resolved By	Resolved Date/Time	Prompt Date KJMB	Prompt Date Lead	
9364	[redacted]	10/7/2015 3:01:06 PM ET	Other (not listed in above categories)		KJMB Solutions Support		Erin Sutka, KJMB	10/21/2015 4:08:51 PM ET	10/11/2015	10/11/2015	View
9417	[redacted]	10/21/2015 3:35:54 PM ET	Referral Entered in wrong PSDCRS project		KJMB Solutions Support		Erin Sutka, KJMB	10/21/2015 11:57:10 PM ET	10/25/2015	10/25/2015	View
9449	[redacted]	10/28/2015 10:14:32 AM ET	Data Fix for Client/Episode/Periodic/etc...	Spelling Error/Typo	KJMB Solutions Support		Erin Sutka, KJMB	10/30/2015 10:32:53 PM ET	11/01/2015	11/01/2015	View
9577	[redacted]	11/10/2015 10:51:54 AM ET	Data Fix for Client/Episode/Periodic/etc...	Spelling Error/Typo	KJMB Solutions Support		Erin Sutka, KJMB	11/11/2015 11:30:01 AM ET	11/14/2015	11/14/2015	View
9863	[redacted]	12/16/2015 8:58:48 AM ET	Client Entered in wrong PSDCRS project		KJMB Solutions Support		Sheila Ramirez, KJMB	12/31/2015 12:07:34 AM ET	12/20/2015	12/20/2015	View
9921	[redacted]	12/29/2015 2:56:35 PM ET	Data Fix for Client/Episode/Periodic/etc...	Did not have information at time of data entry	KJMB Solutions Support		Sheila Ramirez, KJMB	1/4/2016 4:56:26 PM ET	01/02/2016	01/02/2016	View

Table Notes:
Tickets shown are tickets opened within the date range specified.

In addition, the types and sophistication of data and analysis by the Department is also different than in years past. For example, the Department began constructing forecasts/ population projections three years ago. These data aid in determining the likely placement landscape months and often years in advance. This assists the Department in making decisions about the category of services in which it will need to more greatly invest (e.g., congregate versus community-based).



These projections have been amazingly accurate. In 2014, the Department determined that it should down-size its congregate settings to shift funding toward the majority of youth being in the community. At that time, we estimated that in a few

years roughly 90% of the children in care with the Department would be in a community, family based setting. Our current estimate indicates that this projections is on course. (e.g., 91% in community and 9% in a congregate setting).

As the Most recently, the Department has begun to disaggregate these projections by key demographics such as race/ethnicity, gender and age cohorts. This enhanced view of the forecasts allow us to more adroitly develop a service array that will better meet the needs of the children and youth who we expect to serve. We will be working with our statistician to construct multivariate forecasts to allow for even more complex trend projections.

In addition, Program Development and Oversight Coordinators (PDOCs) are assigned to all of DCF's direct services contracts. These individuals are expected to partner with contracted providers, Regional/Area Office Staff, Systems Program Directors (SPDs), and Central Office Divisions to ensure the provision of effective quality services. Ensuring that the PDOCs and SPDs have the necessary skills and direction to successful fulfill their responsibilities is crucial. The Department has begun meeting with the PDOCs, SPDs, and Grants and Contracts Specialist as a joint group to share the Department's priorities and to disseminate data and other resources. More advanced metrics training has been provided (i.e., Pivot Tables and Advanced Analytics conducted by Chapin Hall out of the University of Chicago) to support them in conducting more depth analyses of provider program data.

Last year, in collaboration with its contracted providers the Department launched a comprehensive training curriculum for PDOCs, SPDs, and Grants and Contract Specialist. The topics included:

- PDOC Guide Review
    - Role Clarification
    - Role Expectations
- Program Development from the Provider Perspective
- Introduction to the Tier System
- Central Office/Area Office Communication
- MOA/MOU
- Grants Development
- Service Development: Evidence-Based Practice
- Requests for Proposal
- Scopes of Service
- Amendments, Renewals
- Personal Service Agreements, and Budgets
- Rate Setting
- Risk Management
- Licensing
- Site Visits
- Results Based Accountability (RBA)
- RBA & Working with Providers
- PIE

The results from that training are below. The scores are based on a 1 to 5 Likert Scale, with 5 being the highest. As these data suggests, the desired goals and outcomes from that training were achieved:

Program Development and Oversight Coordinator Training Series – EVALUATION							
Date - Number of Attendees (A) # of evaluations (E)	Training	a. Content was applicable to my job		b. Content could be applied to practice and enhance my professional expertise		c. The presenter was knowledgeable in the content area.	
		Total	Average	Total	Average	Total	Average
3/16/2015 47 A 39 E 39x5=195 Max score	PDOC Guide: Review Role Clarification, Expectation	178	4.5	172	4.4	185	4.7
	Introduction to TIER System	175	4.5	168	4.3	187	4.8
	Central Office/Area Office Communication	181	4.6	161	4.1	172	4.4
	Memorandum of Agreement/Memorandum of Understanding	155	4	161	4.2	163	4.3
3/23/2015 42 E 35x5=175 Max score	Grants Development	155	4.4	164	4.7	175	5
	Service development:EBP	158	4.5	161	4.6	168	4.8
	Request for Proposal	165	4.7	164	4.7	166	4.7
	Scopes of Service ISOS	167	4.8	167	4.8	169	4.8
4/6/2015 43 A 36 E 36x5=180 Max score	Amendments, Renewals, PSA, Budgets	168	4.6	165	4.5	167	4.6
	Rate Setting	154	4.3	149	4.1	171	4.7
	Licensing	157	4.4	159	4.4	180	5
	Site Visits	162	4.5	162	4.5	171	4.7
4/13/2015 39 A 30 E 30x5=150 max score	Developing and Using RBA Report Cards/Using PIE to Report your Data	138	4.6	140	4.7	149	4.9
	RBA and Provider Partnership	138	4.6	140	4.7	145	4.8

Pursuant to the PDOC General Role and Expectation guidance, "[t]he PDOC is expected to monitor and coordinate the quality and effectiveness of the programs under their purview. They are to work with providers, the Regions and other DCF offices and units with respect to assuring quality, supporting services' sustainability, and facilitating ongoing service improvement."

The guidance further states "[t]he PDOC must understand, engage, use and disseminate data, both qualitative and quantitative, about their service(s). These positions should ensure that providers are achieving the outcomes outlined in their [Scope of Services] and work with them to ameliorate areas of challenge and underachievement [and] . . . develop strategies for improvement."

As a means to provide information exchange and support program oversight, PDOCs are expected to convene regular meetings with DCF contracted providers (i.e., no less than quarterly.) The discussion of data is to be a standing agenda item at these meetings. The Department's Senior Leadership also meets regularly with the Provider Associations and convenes two meetings of all its POS Contracted Providers and Credentialed Services Providers. The PowerPoint and other materials from the last statewide provider meeting can be viewed on the DCF website via the following link. The meeting was also televised and can be found on CTN. These meetings are held at the auditorium at Central Connecticut State University. The last meeting occur in August 2015. The next session will be scheduled after the current Connecticut legislative session has ended.

Further, PDOCs and Regional Systems Program Directors use data from PIE to assess program effectiveness, performance, and compliance. Quarterly Results Based Accountability (RBA) Report Cards are created. These report cards ask the key questions of *How Much Did We Do?, How Well Did We Do It?* and *Is Anyone Better?* As racial justice is a cross cutting theme for the Department, we have added the question of "*Who is Better Off*?" This requires that all RBA Report Cards include representations of data tabulated by race and ethnicity. Some RBA Report Cards are posted on the DCF website and can be accessed via the following link.

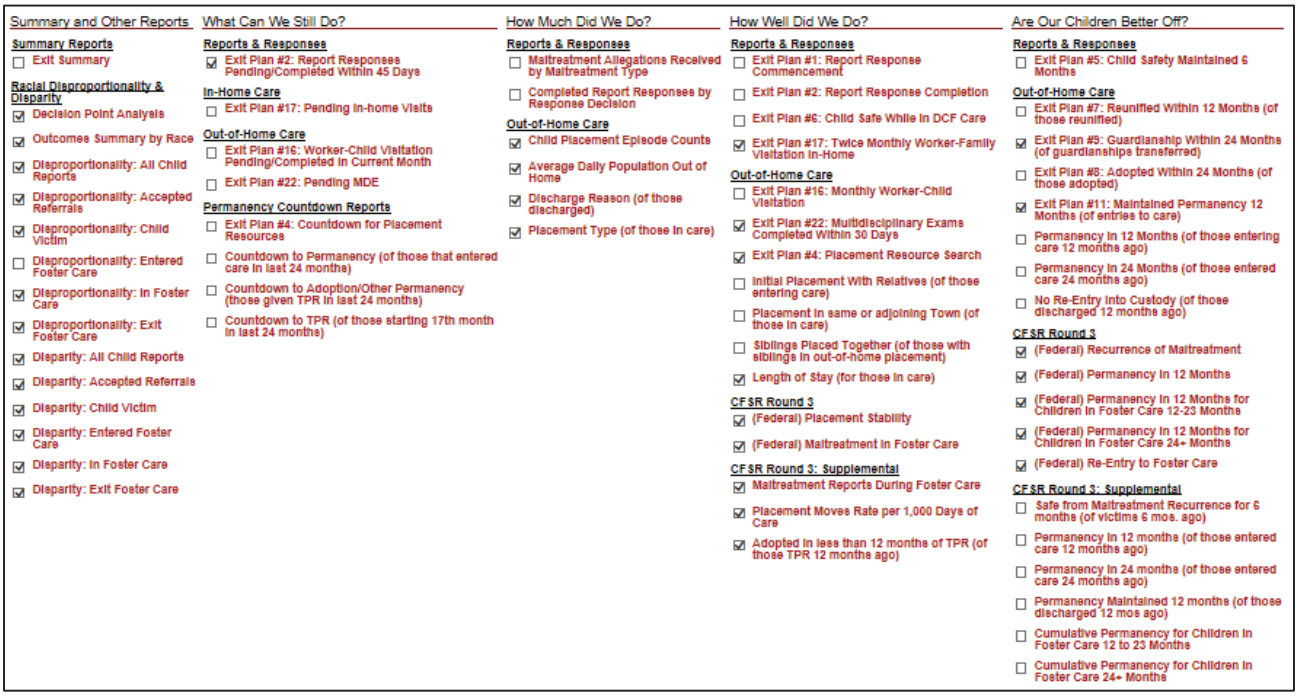
Related, The Department convenes a Service Array Review and Assessment (SARA) meeting every other week. The SARA includes participation by the Commissioner, the Deputy Commissioners, the Chief of Staff, the Chief of Quality and Planning, the Chief Fiscal Officer, the Regional Administrators, the Children's Administrators (i.e., Clinical/Community Support and Congregate/JJ/and Foster Adoption), the Contracts Management Director and the Performance Management Director. This body makes decisions about major service and program funding priorities. The SARA discusses service gaps and challenges, contract management and oversight issues, performance expectations, and outcomes. The SARA has also promulgated a variety of guidance tools to better support program oversight, outcome management, and data informed decision making.

The SARA is also the body in which the POS RBA Report Cards are presented. Every month, four different service type report cards are presented by the PDOCs at the SARA. Since July 2015, nearly 40 RBA Report Cards have been reviewed and discussed at this meeting. Sample meetings from a SARA meeting have been included as an Appendix to demonstrate these Report Cards are used to identify service system strengths, challenges and gaps.

For example, review of the RBA report cards seemed to suggest recurrent underutilization of community-based services by children and families of color, particularly African Americans. An analysis of PIE utilization data suggests that only 17% of children served are Black. This is comparatively low in relationship to the fact that African American children are 21% of our open cases, over 25% of the children in DCF care and are 38.2% of the arrests in congregate settings.

As a means to better assess whether there was potentially pervasive disproportionality, the Chief of Quality and Planning charged ORE to develop a dashboard report to consolidate outcome data from various DCF funded services by race and ethnicity. This report is still in development, but will be informative to determining where disproportionality and disparity may exist with the Department's service system.

Also, the Department will soon be launching its newly enhanced Results Oriented Management (ROM) system. A number of canned reports will be available to monitor disproportionality and disparity impacting a variety of DCF outcomes areas (e.g., entry, victims, permanency, etc.). The below is a screenshot of the report that will be available in ROM.



Summary and Other Reports

Summary Reports
- ☐ Exit Summary

Racial Disproportionality & Disparity
- ☑ Decision Point Analysis
- ☑ Outcomes Summary by Race
- ☑ Disproportionality: All Child Reports
- ☑ Disproportionality: Accepted Referrals
- ☑ Disproportionality: Child Victim
- ☐ Disproportionality: Entered Foster Care
- ☑ Disproportionality: In Foster Care
- ☑ Disproportionality: Exit Foster Care
- ☑ Disparity: All Child Reports
- ☑ Disparity: Accepted Referrals
- ☑ Disparity: Child Victim
- ☑ Disparity: Entered Foster Care
- ☑ Disparity: In Foster Care
- ☑ Disparity: Exit Foster Care

What Can We Still Do?

Reports & Responses
- ☑ Exit Plan #2: Report Responses Pending/Completed Within 45 Days

In-Home Care
- ☐ Exit Plan #17: Pending In-home Visits

Out-of-Home Care
- ☐ Exit Plan #16: Worker-Child Visitation Pending/Completed in Current Month
- ☐ Exit Plan #22: Pending MDE

Permanency Countdown Reports
- ☐ Exit Plan #4: Countdown for Placement Resources
- ☐ Countdown to Permanency (of those that entered care in last 24 months)
- ☐ Countdown to Adoption/Other Permanency (those given TPR in last 24 months)
- ☐ Countdown to TPR (of those starting 17th month in last 24 months)

How Much Did We Do?

Reports & Responses
- ☐ Maltreatment Allegations Received by Maltreatment Type
- ☐ Completed Report Responses by Response Decision

Out-of-Home Care
- ☑ Child Placement Episode Counts
- ☑ Average Daily Population Out of Home
- ☑ Discharge Reason (of those discharged)
- ☑ Placement Type (of those in care)

How Well Did We Do?

Reports & Responses
- ☐ Exit Plan #1: Report Response Commencement
- ☐ Exit Plan #2: Report Response Completion
- ☐ Exit Plan #6: Child Safe While in DCF Care
- ☑ Exit Plan #17: Twice Monthly Worker-Family Visitation In-Home

Out-of-Home Care
- ☐ Exit Plan #16: Monthly Worker-Child Visitation
- ☑ Exit Plan #22: Multidisciplinary Exams Completed Within 30 Days
- ☑ Exit Plan #4: Placement Resource Search
- ☐ Initial Placement With Relatives (of those entering care)
- ☐ Placement in same or adjoining Town (of those in care)
- ☐ Siblings Placed Together (of those with siblings in out-of-home placement)
- ☑ Length of Stay (for those in care)

CFSR Round 3
- ☑ (Federal) Placement Stability
- ☑ (Federal) Maltreatment in Foster Care

CFSR Round 3: Supplemental
- ☑ Maltreatment Reports During Foster Care
- ☑ Placement Moves Rate per 1,000 Days of Care
- ☑ Adopted in less than 12 months of TPR (of those TPR 12 months ago)

Are Our Children Better Off?

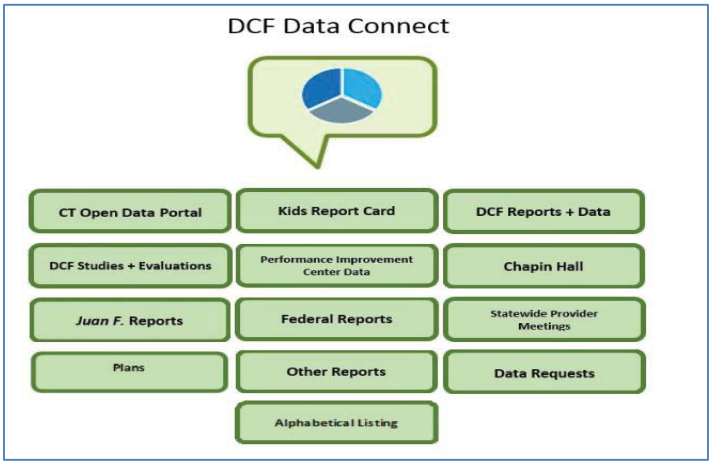
Reports & Responses
- ☐ Exit Plan #5: Child Safety Maintained 6 Months

Out-of-Home Care
- ☐ Exit Plan #7: Reunified Within 12 Months (of those reunified)
- ☑ Exit Plan #9: Guardianship Within 24 Months (of guardianships transferred)
- ☐ Exit Plan #8: Adopted Within 24 Months (of those adopted)
- ☑ Exit Plan #11: Maintained Permanency 12 Months (of entries to care)
- ☐ Permanency in 12 Months (of those entering care 12 months ago)
- ☐ Permanency in 24 Months (of those entered care 24 months ago)
- ☐ No Re-Entry into Custody (of those discharged 12 months ago)

CFSR Round 3
- ☑ (Federal) Recurrence of Maltreatment
- ☑ (Federal) Permanency in 12 Months
- ☑ (Federal) Permanency in 12 Months for Children in Foster Care 12-23 Months
- ☑ (Federal) Permanency in 12 Months for Children in Foster Care 24+ Months
- ☑ (Federal) Re-Entry to Foster Care

CFSR Round 3: Supplemental
- ☐ Safe from Maltreatment Recurrence for 6 months (of victims 6 mos. ago)
- ☐ Permanency in 12 months (of those entered care 12 months ago)
- ☐ Permanency in 24 months (of those entered care 24 months ago)
- ☐ Permanency Maintained 12 months (of those discharged 12 mos ago)
- ☐ Cumulative Permanency for Children in Foster Care 12 to 23 Months
- ☐ Cumulative Permanency for Children in Foster Care 24+ Months

The Department is also enhancing access by stakeholders to meaningful data and reports. In February 2016, the Department launched DCF Data Connect. It provides links to a host of DCF related data portals, relevant reports, evaluations/studies, and plans. For example, on the CT Open Data Portal, the Department has posted a variety of data, including nearly a decade of non-identifiable datasets regarding children in DCF placement. These data postings support the Departments efforts to be accountable and transparent. It also aids with stakeholders such a researchers having more ready access to raw data needed to assess a variety of facets of the Department's work. Access to the Data Connect can be obtained via the below hyperlinked graphic. (see also Item 31 regarding how these data are used with community stakeholders)



In 2007, the Department began a process to standardize the services purchased most frequently through wraparound funding. The services and the fees charged varied widely across the state and no standards were in place for the individuals that delivered the services. From the original list of six services, the credentialed services have expanded to those listed below:

- After School Services: Clinical Support for Children
- After School Services: Clinical Support for Youth
- After School Services: Traditional
- After School Services: Youth

- Assessment
- Assessment: Perpetrator of Domestic Violence
- Behavior Management[13]
- CHAP Case Management (open to current CHAP providers only)
- Supervised Visitation
- Support Staff
- Temporary Care Services
- Therapeutic Support Staff
- Transportation: General Livery
- Transportation: School

In order to provide these services, individuals and organizations must apply for credentialing, including documentation of meeting the requirements to provide the service, such as education and certifications. They must also provide evidence of criminal and child protective services background checks. If accepted, they must sign a provider agreement that clearly describes the service requirements and the details of invoicing and payment. All credentialed service providers undergo re-credentialing every 2 years.

Through competitive a procurement, Advanced Behavioral Health was selected to oversee the credentialing process for providers seeking to enter into provider agreements with the Department. Their responsibilities include:

- Developing and distributing applications, using the DCF's definition of eligible programs and credentialing criteria for providers;
- Receiving all applications and re-applications for enrollment as a DCF provider;
- Reviewing the applications for completeness and accuracy;
- Conducting verification of an individual-specific basis for professional services applicants;
- Reviewing background information that is submitted with the individual's application including criminal records, CPS registry and sex offender registry;
- Reviewing the Federal Office of the Inspector General's website registry of professional healthcare providers and entities excluded from participation in federal healthcare programs;
- Serving as a liaison between the Department and the providers and participating as a member of the Credentialing Committee;
- Maintenance of a database with current information on credentialed providers including disposition on pending applications;
- Tracking the bi-annual interval for re-credentialing, and sending out the re-credentialing application to currently credentialed providers;
- Receiving and recording complaints regarding provider service quality and performance;

[13] *This service is now covered under Medicaid and is being phased out as a DCF credentialed service*

- Conducting quality site visits for all After School programs to assure the program is offered in a safe and secure setting.

There is also a Program Director from the DCF Contracts Management Division who oversees these services, and meets regularly with all the Credentialed Services providers. The credentialing unit and the licensing unit developed a site visit tool for use with credentialed service providers that have more than one person credentialed. We are still working on a systematic way to monitor the single providers.

Site visits are in process now with all of the Therapeutic Support Services providers, as that is the largest of the services in terms of dollars spent and amount of service delivered. The tool mirrors the Provider Agreement and includes case record review as well as review of billing practices. Careline reports whether substantiated or not, are also reviewed at the time of receipt and during the site visit

In addition, the workers and supervisors in the regions are asked to provide information on problems with individual providers to their System Development PDs. The Grants and Contracts Specialists track these complaints and assist in investigating and resolving them. ABH still maintains the ability to capture complaints through their website, but that feature has not been well-utilized by our staff.

The Department also has contracts with entities that serve as Performance Improvement Centers (PICs). These bodies provide technical assistance to aid with service quality and outcomes of care. Some of the functions of a PIC include:

- Developing documents, identifying screening and assessment measures, and measuring treatment fidelity across sites.

- Identifying training needs, developing a standardized training curriculum, identifying expert trainers, ensuring delivery of required trainings, and ensuring the quality and effectiveness of the training curriculum.

- Analyzing data to ensure services are accessible and capacity is sufficient and ensure that services are of the highest quality.

- Identifying important goals and associated outcomes and measuring achievement of those goals.

There are currently two PICs. The below chart identifies the PICs and the entity that administers them. The follow link connects to the various reports and data created by these entities:

PIC Type	Contracted Entity
Emergency Mobile Psychiatric Services (EMPS)	Child Health and Development Institute (CHDI)
Differential Response Services (DRS)	UCONN School of Social Work

Related, the Department has also invested in a variety of Evidence Based Services (EBPs) (e.g., Multi-Systemic Therapy (MST), Multi-Dimensional Functional Therapy (MDFT)). These types of services do not require an additional PI.C as EBPs are delivered under an established host of quality and fidelity measures and expectations in order to ensure effective service provision and model conformance. These outcomes are closely monitored by the EBP model developers.

Every year a list of contracts are required to be renewed. Part of the renewal process has been sending out a survey to the area office's asking for comment on the specific contracts. We now beginning to collect feedback from DCF staff in real time with the ability to sort the responses by contractor, service, Region or Area Office. When the provider closes out a case from a contracted service they are to send an e-mail to the DCF staff who is assigned the case. The e-mail instructs the DCF staff to click on a link which brings them to the internal DCF SharePoint site where they fill out a very brief survey.

The Department shares agency specific results with the Provider on a quarterly basis. This is intended to be a learning tool for both the Department and the Provider. The name of the DCF staff who filled out the survey is included in the response. This enables DCF or the provider to follow up with the individual who filled out the survey if they want more information about their experience.

Finally, the Department is introducing a Tier Classification System for its contracting. The Tier System is a program classification tool designed to enhance the Department's ability to evaluate contracted programs and create opportunities for ongoing Quality Improvement at a program and system level. The Tier system will help enhance internal partnerships among various DCF units and will enhance of the partnership between DCF and its contracted providers.

In April 2015, the DCF formed a workgroup of internal and external stakeholders to work to develop a Tier Classification System that aligned several areas of work within the Department and formalize existing practices used to assess program performance. After several months of collaborative work, in December 2015, the DCF Tier Classification System was finalized and disseminated out to all DCF funded providers. Additionally, informational sessions were held at various non-profit Trade Association meetings and DCF Area Offices throughout the process to ensure adequate communication of this system to all stakeholders. As is noted in Item 32, the Department works with a variety of community and other stakeholders through advisory committees and work groups. Other initiatives such the development of CT's Children's Behavioral Health Plan, which came from legislation following the Sandy Hook school shootings, is another example of how the Department has and continues to collaborate with stakeholders. That plan and its recommendations emanated from multiple community, parent and child focus groups and other input mechanisms.

Finally, the Tier System measures general contractual requirements defined by the Department, in collaboration with provider partners. There are 25 requirements. They are broken down as follows:

Foundational Items (5 items): Review of health and safety info, written Continuous Quality Improvement plans, submission of data, written cultural competency plan, subcontract oversight.

6 Domains (20 items):

- Utilization & Timeliness
- Program Performance
- Cultural Competence
- Client/Family Feedback
- Staffing
- Administrative Performance

The requirements are grouped into three Tier Classifications and an additional Provisional Tier. They are as follows:

Tier I: A program is classified as Tier I when the program meets all applicable foundational requirements and is meeting all but two or less of the elements of performance in the six domains.

Tier II: A program is classified as Tier II when the program meets all applicable foundational requirements and is meeting all but three or four of the elements of performance in the six domains.

Tier III: A program is classified as Tier III if any one of the applicable foundational requirements and/or five or more of the elements of performance in the six domains are not met.

Provisional Tier: New programs will have up to one year to meet Foundational elements and Elements of Performance before being classified, and may be classified sooner at the program's request.

Tier Classification of DCF funded programs began in February 2016. The following DCF funded programs were chosen to be in the first round of classification and will be scored by July 2016:

- Outpatient Psychiatric Clinics for Children/Child Guidance Clinics (26 total)
- One-on-One Mentoring programs (8 total)
- Fostering Responsibility, Education, and Employment (FREE) (6 total)
- Supportive Work, Education, and Transition Program (SWETP) (8 total)
- Short-Term Assessment and Respite Homes (STAR) (9 total)

Notables:

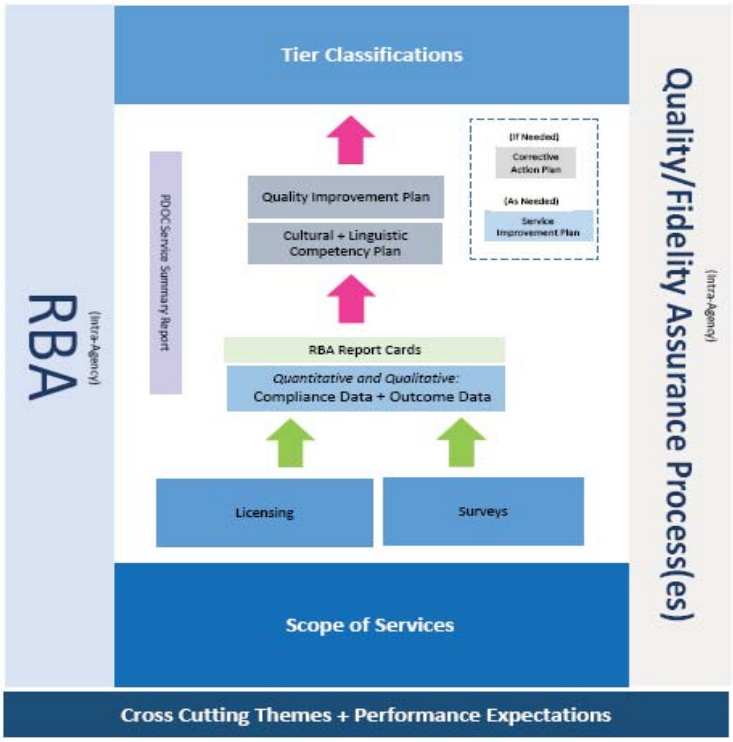
- All data related to the scoring of programs will be housed in the Statistical Package for Social Sciences (SPSS) database. All DCF funded programs will receive a written report for review before the Tier Classification becomes final.
- Service Development Plans and Corrective Action Plans will now use standardized forms and processes for review.
- Tier Classifications and Licensing visits will be coordinated by the end of 2017.
- Bi-Monthly Tier System Implementation Meeting with stakeholders will begin in April 2016
- Program models to be included in Round II of Tier Classification will be determined at the conclusion of Round I.

DCF is committed to working with our contracted providers as partners in service delivery to Connecticut's children and families. The Department recognizes that there are unique implementation challenges to be considered when implementing a new system designed to assess contract compliance.

DCF will view programs' initial Tier ratings as a baseline score during the initial phase of this initiative. This phase will allow DCF, along with representatives from our contracted provider agencies, to explore Tier implementation challenges and explore solutions to address those challenges.

The below schema illustrates the integration of the Tier Classification System with the various concepts and activities that are part of the Department's service system oversight structure.

Services Oversight and Performance Management:
Conceptual Integration Model



D. Staff and Provider Training

Item 26: Initial Staff Training

How well is the staff and provider training system functioning statewide to ensure that initial training is provided to all staff who deliver services pursuant to the CFSP that includes the basic skills and knowledge required for their positions?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

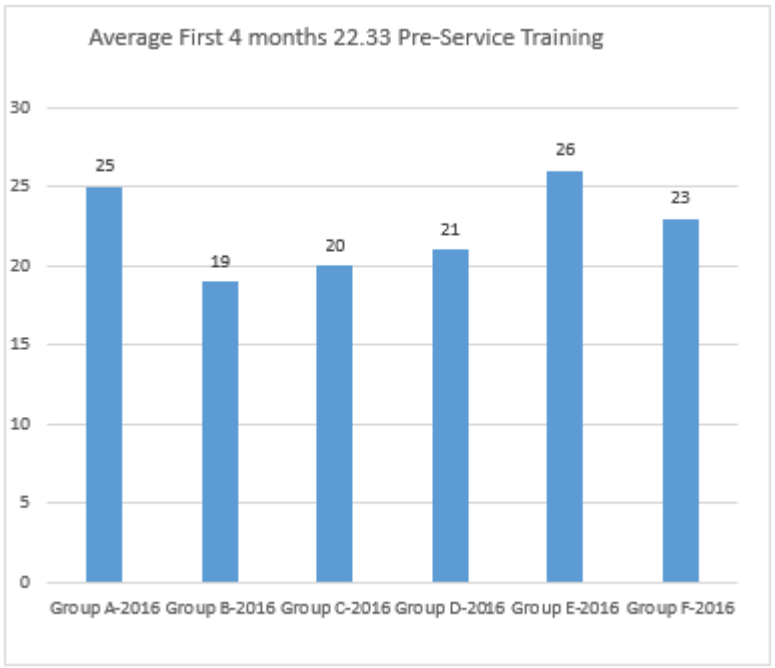
- staff receive training pursuant to the established curriculum and time frames for the provision of initial training; and
- how well the initial training addresses basic skills and knowledge needed by staff to carry out their duties.

State Response:

The Department of Children and Families (DCF) operates an internal Workforce Development Academy with the primary responsibility of offering pre-service training, in-service training, and coaching to both DCF employees and community providers upon request. The DCF Academy provides competency-based, culturally-responsive training in accordance with national standards for practice in public and child welfare. The Academy encourages staff and its community partners to pursue professional education and to utilize learning opportunities to improve their work with children and families. An array of professional development programs are offered on a regular basis. The Academy offers pre-service preparation and in-service training to experienced employees and community service providers to ensure those who work with children and families possess the necessary critical information, knowledge and skills to serve them with the highest level of professionalism.

The Academy for Workforce Development provides an extensive Pre-Service training curriculum to all newly hired Social Workers and Social Worker Trainees. The Department does not contract for the provision of Child Protection Services. Private providers are not utilized for this work, neither as Social Workers nor Social Work Supervisors.

The DCF Academy offers a series of mandatory training modules comprised of 32 days of training over 10 months to all new social workers hired to conduct child welfare-related case activities in the regional offices. Each new hire attends 35 classes. During the first four months, new hires average 22.33 pre-service training day. That ranges from 5- 7 classes per month, depending on what day of the month the training group/cohort starts. The below shows the training days for 6 new hire groups:



The time frames for the training modules over the course of the 10 month period (e.g., Tier 1: first 4 months and Tier 2: Begins at month 5 and concludes by the 10 month of hire) are fixed and generally rigid. Staff are provided with individual training or placed with another cohort that may be covering a given module if a class is missed due to an extraordinary and unavoidable circumstance (e.g., illness).

As these training are tied to the receipt of a full caseload, the Department will individually train, face to face, a new hire if there were an insufficient number of staff to form a cohort. Thus, there is no set "schedule" for the provision of these trainings. Meaning, that a staff person wouldn't have to wait months until the initial training is re-offered. It would be provided to ensure that the new hire have received all the modules of the initial training curriculum within 10 months of their hiring date.

Attendance in training is rigorously monitored. Each morning, new hires attending training are greeted outside of the security desk by Academy staff and are signed in. Persons arriving late are noted on a "Late" sheet. The training facilitators take attendance at the beginning of class and once again after lunch. The Department maintains training attendance in the Learn Management System. Any absentees or late arrivers are reported to their supervisor.

The Department maintains a centralized Academy for initial and much of the ongoing training. Training of new social work staff occurs in cohorts. Clusters of new hires go through a standard array of training modules over a 10 month period. As the receipt of training is tied to new hires' caseload levels and in turn salaries pursuant to the union contract, there is uniformity and diligence in the implementation of training to new social work hires. That is, while staff may take up to a quarter caseload within the 1st month of hire, staff may not have a full caseload until they have completed the first 4 months of training (i.e., completion of Tier 1). Staff receive a cumulatively increasing one quarter of a full caseload until they are up to 100% by the fourth month. By DCF policy, new staff must complete Tier 1 of the initial training by the 4th month of their hire date.

Upon completion of the 4 months of initial training, new hires receive a salary increase. Given the monetary nexus with the completion of training, the Department diligently monitors and tracks this. The Academy is responsible for affirmatively informing Human Resources whether an individual has completed all the required initial training in order to receive a full caseload and in turn the increased salary. Similarly, the Academy informs DCF's information systems division so that the LINK system is updated to remove the "T" designation for staff who are identified as Social Work Trainees.

This centralized training process also ensures that there are no geographic barriers or gaps to the provision and receipt of initial staff training within established timeframes. Moreover, pursuant to DCF policy, Social Work Supervisors must release and/or cover the work of their staff in order to ensure that they are able to attend these mandatory new hire training sessions.

The pre-service program is designed to prepare each staff member for effective protective service/child welfare practice. There are several components to the pre-service program: classroom training at the Academy, supervised casework experience in a training unit in the regional office, and practice level activities (e.g., group supervision component) aimed at enhancing the transfer-of-learning process. In addition to the classroom trainings, new hires are expected to complete the on-line Mandated Reporter Training within a week of starting their pre-service training. There are also documents available to support Social Work Supervisors in orienting their new hires to the work of the agency and to further their classroom learning. Shadowing Guidelines and Transfer of Learning documents are available on the Academy SharePoint site. The Academy has been successful in integrating new concepts into training related to racial justice, interpreting data, safe sleep, health and wellness, and permanency teaming.

The initial training curriculum is comprised of a computer based pre and post-test, an oral presentation and exploration of a case from their caseload utilizing a truncated version of the department's group supervision model, and the writing of assessment components of a case plan based on an investigation protocol and narrative for a sample case. The final tests provide insight on the retention of knowledge from the classroom and field experiences as well as a demonstration of their individual skills. The results of the test are provided to and can be used by supervisors and participants to identify further training needs and areas that need increased proficiency for successful completion of the job. In addition, a formal feedback process with new hires' Supervisors is built into the initial training curriculum at the 3rd and 8th month points.

Furthermore, new social work hires, referred to as Social Worker Trainees (Trainees), are typically placed in a dedicated training unit, with a Training Social Work Supervisor. These units have been developed to better support the professional development, growth and nurturing of Social Worker Trainees. While there is not a hard "pass" or "fail" level for these the final initial training test, staffs' scores and other feedback from the Academy instructors are sent to each Trainee's supervisor. Scores under 70% will result in a direct outreach to a Trainee's supervisor to review the areas that require focus. The results from the initial training modules are used by the Training Supervisors to inform and guide the additional support and in-service training that they will provide to individual trainees and the training unit. Trainees are also provided with the opportunity to re-take select initial training classes to support their competencies.

Staff are considered Social Worker Trainees until they have successfully completed two years of work at that level. Only after having completed two years of employment, are Trainees promoted to the level of Social Worker.

Training Supervisors closely monitor the progress and fitness to the work of their Trainees. As indicated, while the final score on the initial training is not the single determinant as to whether a Trainee will retain employment, Training Supervisors observe new hire and evaluate their ability to do the expected work over the course of a 12 month working test period. In 2014, the Department hired 87 Social Worker Trainees. 17 of these staff did not make it past their working test period (19.54%). In 2015, the Department hired 191 trainees and 31 did not make it past their working test period (16.23%). Reasons for separation from the Department varied from fit for the position, inability to keep up with the daily work responsibilities, and poor work performance.

Averages: On a scale of 1 to 10, with 1 being never used, with 10 being used in every training, how would you rate the use of the following training aides:	
Video	6.66
Lecture	8.55
Handouts	8.22
Table Activities	8
Role Plays	6.85
Case Scenarios	7.44
Others	

Averages: On a scale of 1 to 10, with 1 being not helpful at all and 10 being the best way to learn, how would you rate the benefits of the following training aides:	
Video	9
Lecture	7.33
Handouts	7.33
Table Activities	8.11
Role Plays	6.77
Case Scenarios	10
Others	

Below and to the right is an example of feedback from one of the new hire cohorts that completed the pre-service training:

Training Academy Pre-Service Evaluation: Trainee Group F 2015

Questions:

What best prepared you for the field?

Majority of the trainees agreed they were prepared for the field after participating in courses such as: case planning, legal 1-4, placement and engaging families.

Which part of your pre-service was least helpful?

Majority said that all of training was helpful however one trainee expressed how they already learn this material at another event or on a caseload such as: legal, etc. Overall, everyone answered by saying all information was helpful.

What additional supports would you find helpful?

All of the trainees found that it was helpful to have a mentor or seasoned social worker at the academy. They found it helpful having a mentor they can connect with to utilize for questions,

concerns, and support during the pre-service process.

What topic would you want additional training time to be spent on?

Many wrote there was efficient times in the trainings to learn the material. Majority of the group felt as though the time was well spent.

However a few answered by suggesting spending more time on workers safety.

What topic not covered would like to see/included?

Majority of the group wrote all topics were covered and some suggested having more providers come in to talk about their programs as well as real world situations they might encountered.

What would have improved your training experience?

A lot expressed having more group activities to engage everyone in different points of training.

Also, some recommended having more guest speakers come in to talk about their experience.

Please add any additional comments that you would like to add.

Majority of the group did not write a response for this question.

One wrote how the trainers were great and it was a privilege to work with them.

Item 27: Ongoing Staff Training

How well is the staff and provider training system functioning statewide to ensure that ongoing training is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Staff, for purposes of assessing this item, includes all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Staff, for purposes of assessing this item, also include direct supervisors of all contracted/non-contracted staff who have case management responsibilities in the areas of child protection services, family preservation and support services, foster care services, adoption services, and independent living services pursuant to the state's CFSP.

Please provide relevant quantitative/qualitative data or information that show:

- that staff receive training pursuant to the established annual/bi-annual hour/continuing education requirement and time frames for the provision of ongoing training; and
- how well the ongoing training addresses skills and knowledge needed by staff to carry out their duties with regard to the services included in the CFSP.

State Response:

The Academy continues to recognize the value of providing staff with an array of in-service trainings that will strengthen their competency level. In-service training is available to all staff and is offered throughout the year. Training classes are posted in an online catalog, and staff can "self-register" with supervisory approval.

Per agency policy, all staff must attend five days of in-service training annually. The Department has implemented a new online process to support registration of and in turn monitoring of in-service training. As has been noted, the Department uses the Learning Management System to track attendance at all training conducted by the Academy. These training requirements are expected even if staff have matriculated in an advanced degree program.

In addition, the Department has adopted a supervision model. The components of this model (see "In-Service for Supervisors" section below for additional detail) require staff to complete "Session Agendas" for each person they supervise. Professional development and completion of required training are to be standing topics of the agenda. Thus completion of training is also to be monitored via supervision using the Session Agenda process and supervisor's access to the Learn Management System portal.

In January of 2016, the Academy launched its new in-service catalog. The catalog is issued quarterly allowing staff ample time plan and schedule training activity. In addition, the Academy also launched a self-training registration process along with ability all staff and supervisors view training completed on the Learn Management System. This will greatly assist staff with managing compliance of the mandatory training requirements. Supervisors are encouraged to regularly discuss learning opportunities during formal supervision and document such discussions on the supervisory Session Agenda in the professional growth and development section.

From 2014 to the present, the primary in-service priority of the Academy has been to ensure that staff are trained in the Permanency Teaming Model. To date, over 2000 DCF staff (the Department averages 3090 total staff) and hundreds of providers have received this two-day training. The training overall has been met with positive response. Staff are able to grasp the model and share a common belief around the positive impact that teaming will ultimately have on the lives of the children DCF serves. As a mechanism to assist with implementation, the Academy has begun to hold non-mandatory monthly permanency conference calls with staff across the state. These monthly calls focus on a different topic related to permanency teaming, ranging from adolescents to implementation to foster care. The conference calls provide an avenue for staff to discuss strategies necessary to embed this model into practice. Attendance at these calls is tracked. Approximately 200 people participate annually.

Certification Programs

The DCF Academy has moved away from using the term “Certification Programs;” and instead refers to specialized, multiple-session training as a “Training Series.”

From 2014 to the present, the Academy has continued to offer the Differential Response System (DRS) Training Series to social work staff from across the area offices and Careline. The DRS Training Series was offered on three occasions, with 89 unique staff participating. Components of this series included a strong emphasis on the following:

- DRS Best Practices
- Worker Safety
- Legal Issues
- Health & Wellness
- Drug Endangered Children (DEC) Program
- Human Trafficking

In response to the large influx of newly hired social workers and social worker supervisors, the Academy offered the TRUST Series (Training Unit Supervisory Training) to training supervisors in the area offices. While not mandatory, this training series is designed to provide new training supervisors with the necessary competencies needed to supervise new trainees. About 20 staff a year participate in this training. The Department has about N Training Supervisors. Components of this series included a strong emphasis on the following:

- Human Resources
- Learning Styles

- Secondary Trauma
- Managing Up

Over recent months, there has been a large emphasis placed on the adolescents in DCF care and ensuring they have the skills and supports necessary to be productive and successful adults. The starting point has to be the social worker and ensuring that they have the knowledge and competencies necessary to work with this population. The Academy will be holding a ten day training series for social workers who maintain caseloads of youth between the ages of 13-23. Some of the topic areas included in this training series are:

- Normal Adolescent Behavior
- Trauma/Risk Taking Behaviors
- Parenting/pregnancy
- Substance Abuse
- Permanency

In-Service for Supervisors

The DCF Academy continues to support the critical role supervision plays in child welfare practice, and has partnered with Yale University to provide a mandatory, two-day training entitled "Strengthening Supervision." The "Strengthening Supervision" model includes three phases of supervision (engagement phase, work phase, and ending & transition phase), which encompass four functions (quality of service, administration, support, and professional development). Supervision purpose, content, frequency, length, and documentation are significant components of the two-day training. Additionally, a large component of the model is grounded in the utilization of group supervision. Group supervision allows for diverse conversation, critical thinking, and effective feedback to play a role in critical case issues. The Academy's efforts to support group supervision are discussed further below. To date, the "Strengthening Supervision" training has been provided to 328 agency social work supervisors. This represents over 98% of the regional Social Work Supervisors (N=334).

Furthermore, the Department has entered into a partnership with the National Child Welfare Workforce Institute (NCWWI) to offer supervisors an opportunity to participate in the Leadership Academy for Supervisors (LAS). The LAS is a web-based leadership training for experienced child welfare supervisors. The curriculum consists of six online modules each based on the NCWWI Leadership Model. The LAS provides 21 contact hours of self-directed online learning, with two tracks to enhance learning transfer: a personal learning plan to develop leadership skills and a change initiative project to contribute to a systems change within the agency. The LAS will be offered to supervisors in October 2015.

Coaching for Regional Supervisors

The Academy has continued to offer non-mandatory coaching to regional supervisory staff, specifically in an effort to support the implementation of the group supervision model. Academy staff inclusive of the assistant director, one program manager, and several child welfare trainers provided coaching to supervisors through a structured, two-day process. Each coaching session occurred in the supervisors' area office, and involved individual conversations about the model, highlighting the benefits and risks of

group supervision; the case discussion method; phases of group development; and other key considerations. Individual conversations between "coach" and supervisor were followed by actual group supervision sessions with the supervisors' assigned staff, first facilitated by the "coach" and on the second day of the process, facilitated by the supervisor. Following the facilitated group supervision sessions, "coach" and supervisor shared feedback, questions, and recommendations for improvement. To date, 24 coaching sessions have occurred across 11 area offices, with 25 supervisors participating.

In-Service for Managers

Managers from the area offices, central office, and the facilities participated in one of several two-day events on "Strengthening Supervision" offered by consultants from the *Yale Program on Supervision.* The purpose of the program was to support current organizational development work by increasing managers' competency in structuring supervision to undergird the current organizational change process. The training program has received both buy-in and feedback from leadership throughout the agency. Feedback from the training sessions continue to be very positive with managers specifically noting that the opportunity to brainstorm ideas, share, and learn from colleagues was extremely valuable. In 2014, an agency policy on supervision was fully implemented requiring all supervisors and managers to conduct and document supervision on a regular basis. Specific practice guidance has been developed for area office staff and efforts to develop a similar guide for central office employees is in progress.

In 2014, the Academy successfully launched the Connecticut Leadership Academy for Middle Managers (LAMM). Mirrored after the national leadership program developed by the National Child Welfare Workforce Institute, this program is designed to enhance the ability of middle managers to apply leadership skills to the implementation of sustainable systems change aimed at improving the lives of children and families. This series of facilitated dialogues and structured learning experiences provide middle managers with an unprecedented opportunity to self- reflect and share their experiences as an affinity group.

The leadership competencies emphasized in the training include: Leading Change, Leading for Results, Leading People and Leading in Context. A basic working assumption of this model is that a flexible structure is necessary for creating the opportunity for each manager to explore and build on his or her own strengths and professional development needs. The process begins with assessing participant's leadership style and strengths. Participants then incorporate performance management, results-based accountability and organizational development tools to support the learning process. Like the national LAMM, each manager is required to identify a Change Initiative ideally to be at least partially implemented prior to the completion of the four month learning experience. Each participant is assigned to a "Super Coach" to provide support, leadership and guidance necessary to successfully implement their Change Initiatives. The 6 "Super Coaches" include four executive level agency staff, a Casey Family Program Strategic Consultant and a former DCF Deputy Commissioner. Additionally, each participant receives individual and group coaching from Academy staff and the Chief of Quality and Planning on an as-needed basis.

This program has far exceeded the expectations of the Department resulting in statewide changes in the system as a result of several successfully implemented Change Initiatives. To date, ~~25~~ managers have successfully completed the program.

This past fall the Department brought the National LAMM to Connecticut. Thirty-five (35) Program Director level staff participated in the two day on site training and continue to work with mentors on their identified change initiatives.

Post Masters Certificate Program

The goal of the Post Masters Certificate Program is to train child welfare professionals, community mental health providers, adoption services providers, and private practitioners to establish a cadre of adoption competent professionals in the community who can offer post adoption services with clinical expertise to children and families, particularly those who have adopted through DCF.

The Certificate Program is a collaboration of the University Of Connecticut School Of Social Work (UCONN-SSW), Southern CT State University (Southern), DCF, and the Adoption Assistance Program at the UConn Health Center. This evidenced-informed training consists of thirteen class sessions held monthly from March to October, which alternate between the two universities. In addition to the classes, six case consultation sessions are provided to enhance the transfer of learning and additional case specific support. The program focuses on cutting edge practices used on a national level to improve services to children and families dealing with a myriad of issues related to permanency. Cross training between DCF staff and providers also creates an opportunity for collaboration and the creation of a shared vision of practice. The feedback from this training program is overwhelmingly positive and has received national attention. The Center for Adoption Support and Education recently requested that this model be used as a demonstration site for the implementation of Training for Adoption Competencies (TAC) program in an effort to create national standards for training on adoption. The 2014-2015 cohort consisted of fifteen DCF employed staff and ten community providers. The TAC students are asked to assess their pre-and post-training levels of competency on thirty-five core competencies. The training is designed to move students from beginning levels of awareness and knowledge to regular, effective application in practice. Feedback reflects consistently positive ratings of TAC quality and relevance.

MSW Field Program

The MSW Field Program began in 2004 in response to a need for additional staff development opportunities for those DCF employees seeking an MSW degree. The program is a replacement for the SWIP (Social Work Internship Program), which is now defunct. First and second year students as well as advanced standing students have benefited from the program. Priority is given to students seeking their second-year field placement. The intent of the program is to foster support of our social workers by allowing them to meet their university requirements for 20 hours of field instruction within their regular 40-hour work week. In essence, no additional field instruction hours are required outside of the regular work week. Staff participating in Field placements are still expected to complete any and all other mandatory DCF training congruent with their position.

A major component of the program is that it allows the social workers to use their place of employment as their field instruction, while maintaining their current caseload within their current unit. A field instructor outside of the student's chain of command is utilized to ensure a separation of work and learning responsibilities. This supports the agency standard of limiting shifting caseloads. It also benefits the families and children served as they are able to maintain continuity of social workers. Finally, it

benefits the social worker as he/she is given the opportunity to keep the caseload they are familiar with, yet learn to service their clients more effectively with predictably better outcomes. Flexibility also is available on a very limited basis to reassign cases or employees to other units to give employees a different learning experience on an as-needed basis and with the consent of the University involved, student's chain of command, MSW field instructor and DCF Academy for Workforce Development.

Additionally, the program prepares students to look for opportunities to provide service "above and beyond the norm;" identify gaps in service delivery and provide solutions; and gain better understanding of DCF as a whole. All of this is accomplished by adhering to a strength-based perspective in keeping with the agency's mission. To date, the program continues to be successful. It has been heralded by social work supervisors, participating universities and students, as they appreciate the new perspectives on cases and learning opportunities for students.

Through a competitive interview process, in 2014-2015 four students participated in the program and successfully completed their field placement. In 2015-2016, eleven students interviewed and ten students will be accepted into the program.

DCF Stipend Program

Internship programs are one of the most effective recruitment strategies used by many professions. These programs are mutually beneficial to both the students and the agency, as the on-the-job experience is a perfect opportunity to determine suitability for the job. Special emphasis has been placed on marketing the internship program as a recruitment tool for child protective service workers. In the fall of 2010, the Academy launched its first student stipend program for external students interested in employment at DCF. In this competitive program, students in their final year of a BSW or MSW program are selected to participate in an internship process in a regional office where they receive orientation, training and real-time experience handling child welfare activities. Students receive a $3,000 stipend to offset the cost of their education and are required to meet agency practice standards. Upon graduation and receiving a recommendation from their field supervisor, students must repeat a background check and an interview process. If successfully completed, students are prioritized in the hiring process. If no positions are available three months after their graduation date, students are released from any obligation to wait for employment or repay the stipend. To date, 44 students have successfully completed the program. Unfortunately, due to a significant decrease in hiring in the past, only nine students from the program have been offered employment to date. The hiring process, however, has resumed in the last two years and the Department's efforts to increase the applicant pool is expected. The Academy has developed a process to streamline the students' applications to the Department's Division of Human Resources who has agreed to prioritize hiring to this intern cohort. This strategy will increase the number of students who apply to the Department and increase the number of qualified applicants being considered for employment.

NCWWI University Partnership

The DCF Workforce Development Academy, in partnership with the UCONN School of Social Work, is the proud recipient of the National Child Welfare Workforce Institute - CT Partnership for The Child Welfare Excellence grant. The CT Partnership offers the opportunity for the UCONN-SSW and the DCF to collaborate with the goal of refining and strengthening foundational and child welfare-related curricula

content to reflect the knowledge and skills that address the increasingly complex needs of diverse families and children served by public child welfare agencies; thereby enhancing competency levels of the CT Partnership trainees and other students alike. In addition, it provides the opportunity to collaborate on mutual objectives of addressing the need to increase the knowledge, skills, abilities and diversity of the public child welfare workforce by targeting recruitment for masters level trainees from within populations under-represented (Hispanic, male, linguistically diverse) in the current DCF welfare workforce; and to increase the pool of masters level, professionally trained social work graduates as one key strategy that can improve the quality of public child welfare practices and outcomes.

The Partnership will result in 35 Master of Social Work (MSW) graduates over a five year period, who are either currently employed at the Department or who will receive priority consideration for employment. The first year's cohort in 2014-2015 included one DCF employee and six students in the traineeship program. The second year cohort will include eight students, two of which are DCF employees. Students accepted in the program will have their final year of graduate study paid in full through this grant ($13,714). Students choose to spend 15 or 20 hours a week in their field assignments in any of the 14 DCF area offices.

Graduate Education Support (GES)

The Graduate Education Support (GES) Program is an educational program to assist DCF employees with two or more years of employment in obtaining either an undergraduate or graduate degree in the field of Social Work/Child Welfare. This program offers employees the opportunity to work a 32 hour work week and 8 hours of work time to devote to their internship. The internship placement can be either external to the Department or at a DCF location other than the current worksite. GES recipients are obligated to complete two months of employment of service for every month of participation in the GES program, equivalent to eighteen months. The 2014 cohort included six employees that applied and were accepted, of which one student withdrew from her educational program and did not participate in the program. The 2015 cohort includes ten employees located across six area offices.

Considered Removal-Child and Family Team Meeting Training

The Department initiated Considered Removal Child and Family Team Meetings (CR-CFTM) three years ago. This approach is designed to engage parents and family in safety planning and placement-related decision-making. Its goals are to safely preserve the family unit and, when children must be placed, minimize the disruption and trauma associated with the removal, placement and separation of the child from his or her family. The consistent and effective use of the CR-CFTM process promotes family engagement and can restore safety, social and emotional well-being and secure family permanence for the child.

Monthly consultation days with the CR-CFTM Facilitators and Casey were held for one year post implementation for coaching, training, and case consultation. All Area Offices are staffed with trained facilitators and back up Facilitators. In October 2013, Annie E Casey conducted a Train-the-Trainer session using Training Academy staff and a number of CR-CFTM facilitators as trainers to ensure sustainability and identify additional back up facilitators in the regions to help support

the work. An additional TOT session was held this year to promote adequate coverage in all regions.

During 2015, Considered Removal- Child and Family Team Meeting (CR-CFTM) Facilitators conducted training to Area Office staff around the CR-CFTM process focusing on model fidelity, importance of parental, youth and relative participation in meetings, and the positive outcomes of family and youth involvement in planning and decision making activities.

Area Office trainings conducted by CR-CFTM Facilitators have occurred to:

- increase staff's understanding of the model and the benefits of the CR-CFTM process;
- emphasize the importance of youth and relative participation in these meetings;
- aid with engaging parents in the CR-CFTM process;
- clarify roles/responsibilities;
- explicate the trigger for these meeting;
- detail the importance of pre-meetings;
- identify the non-negotiables; and
- underscore the importance of a "live decision" and being open to the various options that might be presented.

Permanency Child and Family Teaming Training

Implementation of Permanency Child and Family Teaming is currently underway. A statewide Steering Committee consisting of regional and central office representatives have been meeting monthly since July 2013 charged with overseeing the development and implementation of permanency teaming. The Steering Committee developed three subcommittees focused on key implementation issues: Data, Communications, and Training. Facilitation and Permanency Preparation training has been offered through the Training Academy to Regional Staff. Permanency Preparation training has also been offered to Congregate Care, Therapeutic Foster Care and PPSP providers by national model developer. The Department has also arranged for training of private providers in 3-5-7 (permanency preparation, family engagement), in violence prevention/reduction (Six Core Strategies) and in a trauma informed foster parent training program.

The Training Academy has delivered statewide training on permanency teaming to direct service staff, managers, office directors, and provider staff. Additionally, the Department has provided permanency preparation training by the national developer to congregate care providers, therapeutic foster care providers and PPSP providers to further support the Department's efforts to achieve timely permanency for children.

Quality Assurance and Data Training

DCF is committed to data-informed and strategy-driven management and has implemented annual performance expectations, with all regions, facilities, and central office divisions. All are required to develop detailed operational strategies to achieve the performance expectations. DCF is committed to workforce development opportunities and the importance of providing managerial trainings on strategy

development, the development of outcome-focused strategies, use of data to manage performance, and strategy modification based on performance data. The trainings provided include:

a. Using a results oriented approach to strategy development
b. Identification of performance measures, with a focus on outcomes
c. Using data to manage performance
d. Using performance data to analyze effectiveness of strategies and to inform strategy modification

With respect to Quality Assurance, staff training is another means by which the Department will be improving outcomes. Program Development and Oversight Coordinators (PDOCs) are assigned to all of DCF's POS contracted services. These individuals are expected to partner with contracted providers, Regional/Area Office Staff, Systems Program Directors (SPDs), and Central Office Divisions to ensure the provision of effective quality services. Ensuring that the PDOCs and SPDs have the necessary skills and direction to successful fulfill their responsibilities is crucial.

The Department has begun meeting with the PDOCs, SPDs, and Grants and Contracts Specialist as a joint group to share the Department's priorities and to disseminate data and other resources. More advanced metrics training has been provided (i.e., Pivot Tables and Advanced Analytics conducted by Chapin Hall out of the University of Chicago) to support them in conducting more depth analyses of provider program data.

Broader data and Quality Assurance training for DCF Child Protection Staff has also been developed. The Department is collaborating with Casey Family Programs to create a data curriculum for DCF staff and to bring a child welfare data fellowship initiative to Connecticut. In addition, the Department's Workforce Development/Training Academy is working to embed greater data and outcome measurement exposure into the pre-service curriculum for DCF Social Worker Trainees.

The Contract Management Unit designed and executed a comprehensive training curriculum for the 34 PDOCS, the 6 grant and contract specialists housed in the regions, and 6 Regional System Program Directors. The training encompassed 20 critical training areas that were delivered in four sessions, four hours per session. The goals of the training were to:

- Create consistent expectations across services
- Provide tools and supports to allow PDOCs to fulfill responsibilities
- Strengthen partnerships and communications among DCF staff to improve service development and evaluation
- Strengthen partnerships and communications with providers

The evaluation results from that training are below:

Program Development and Oversight Coordinator Training Series –

EVALUATION RESULTS

Program Development and Oversight Coordinator Training Series – EVALUATION							
Date - Number of Attendees (A) # of evaluations (E)	**Training**	**a. Content was applicable to my job**		**b. Content could be applied to practice and enhance my professional expertise**		**c. The presenter was knowledgeable in the content area.**	
		Total	Average	Total	Average	Total	Average
3/16/2015 47 A 39 E 39x5=195 Max score	PDOC Guide: Review Role Clarification, Expectation	178	4.5	172	4.4	185	4.7
	Introduction to TIER System	175	4.5	168	4.3	187	4.8
	Central Office/Area Office Communication	181	4.6	161	4.1	172	4.4
	Memorandum of Agreement/Memorandum of Understanding	155	4	161	4.2	163	4.3
3/23/2015 42 E 35x5=175 Max score	Grants Development	155	4.4	164	4.7	175	5
	Service development:EBP	158	4.5	161	4.6	168	4.8
	Request for Proposal	165	4.7	164	4.7	166	4.7
	Scopes of Service |SOS	167	4.8	167	4.8	169	4.8
4/6/2015 43 A 36 E 36x5=180 Max score	Amendments, Renewals, PSA, Budgets	168	4.6	165	4.5	167	4.6
	Rate Setting	154	4.3	149	4.1	171	4.7
	Licensing	157	4.4	159	4.4	180	5
	Site Visits	162	4.5	162	4.5	171	4.7
4/13/2015 39 A 30 E 30x5=150 max score	Developing and Using RBA Report Cards/Using PIE to Report your Data	138	4.6	140	4.7	149	4.9
	RBA and Provider Partnership	138	4.6	140	4.7	145	4.8

The evaluations were scored on a Likert Scale that ranged from 1-5, with "5" being the highest. Based upon the evaluations, it appears that PDOCs attending this training felt the various modules supported professional development related to their job functions.

Provider Training

As a means to support training for foster parent, the Department has a contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) that includes a range of support, education, training, and advocacy services to foster families, adoptive families and relative caregivers intended to address and meet their needs, encourage and facilitate ongoing education and skill development, and allow foster children to live in safe and stable home settings.

For families licensed by private agencies (e.g., Therapeutic Foster care), their training is tracked by their parent agencies. The Department engages in periodic random reviews during quality assurance site visits to assess each providers systems and will make recommendations for improvements.. Please see Item 28 regarding TFC training outcomes.

There have been two TIPS-MAPP trainings to date. 26 participants at each for a total of 52. These first two have included staff from DCF and from the TFC agencies. There is another training in June that will be all TFC staff - again 26. A 4th training will take place in September - another 26 of both DCF and TFC. We are in the process of trying to secure funds for some additional training. There are two staff from

DCF - one from Region 4 FASU and one from the Training Academy who are in the process of becoming certified in TIPS-MAPP so they can train. TIPS-MAPP overview training for DCF Staff has been schedule for the first quarter of 2016:

TIPS MAPP: WHAT IS IT? AN OVERVIEW OF THE NEW FOSTER PARENT TRAINING CURRICULA

Target Audience: All DCF Staff

The TIPS MAPP curricula provides a trauma-informed understanding for our foster families, as well as a connection to the importance of everyone working together for the child. It is child-centered and highlights the importance of foster parents understanding children's trauma, culture, and the value of their immediate and extended family members. Finally, the training ensures the foster parent experiences life through the child's eyes. In this overview course, DCF staff will have an opportunity to participate in activities that will benefit their expectations and dialogue with foster families. Staff will gain insight into the TIPS MAPP process, and what to expect regarding shared responsibilities.

Date	*Time*	*Trainer*	*Location*	*CEU's*
1-19-16	***9-4***	***Lesley Gertner***	***Central Office (Room 7)***	
2-17-16	***9-4***	***Lesley Gertner***	***Central Office (Room 7)***	
3-9-16	***9-4***	***Lesley Gertner***	***Central Office (Room 4)***	

Click here to register

Next, staff at congregate care facilities are monitored by the Department's Licensing Unit for completion of mandatory training (e.g., CPR, first aid, ESI, mandated reporting). Over the past year, the Department has conducted 47 re-licensing visits at child caring facilities (each facility must be relicensed every two years). During 13 of those visits providers were cited for having at least one staff member who did not have evidence of the required trainings in their personnel file. On 8 occasions, providers were cited for missing CPR certifications, and on 9 occasions providers were cited for staff not having completed training on emergency safety interventions (restraint and seclusion). The most common scenario involved newly hired staff members (less than 2 months) who had not yet received the required training, or more senior staff who were late in receiving an annual update.

The DCF Office of Children and Youth in Placement (O'ChYP) has begun to message to all congregate care providers the need for annual staff training plans. The plans would be submitted to the Department on an annual basis and feedback provided. This language has been added to the Scopes of the TGHs, but these amendments have not yet been executed.

Area For Enhancement:

While the Academy for Workforce Development collects evaluation surveys from staff who attend these trainings, these data are not systematically compiled. We are seeking technical assistance through the Center for Capacity Building for States to aid us in devising a process whereby we can analyze and better utilize this rich information to better ensure each trainings' quality effectiveness.

Item 28: Foster and Adoptive Parent Training

How well is the staff and provider training system functioning to ensure that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children?

Please provide relevant quantitative/qualitative data or information with respect to the above-referenced current and prospective caregivers and staff of state licensed or approved facilities, that care for children receiving foster care or adoption assistance under title IV-E, that show:

- that they receive training pursuant to the established annual/bi-annual hourly/continuing education requirement and time frames for the provision of initial and ongoing training.
- how well the initial and ongoing training addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.

State Response:

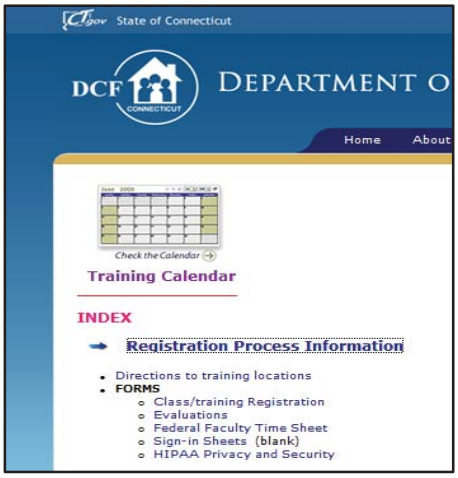
In Connecticut, prospective non-relative foster and adoptive parents are required to take a pre-licensing training curriculum that lasts for 10 weeks (TIPS-MAPP). Each week's session is three (3) hours in duration. It is an assessment period. In addition to the training, the Department also requires homework assignments and a minimum of two (2) home visits during which time much is learned about the family that also serves to inform the assessment. Families are not licensed if they do not satisfactorily complete the training. The Department only recently transitioned from using the PRIDE curriculum to the TIPS-MAPP curriculum due to its grounding in trauma-informed concepts. TIPS-MAPP does have evaluative components that collect the prospective foster parent's assessment of what they learned and their satisfaction with the training. This information is reviewed in each Region and informs future trainings. Parents caring for children with complex behavioral health and/or medical needs are also provided with child specific training. In particular, the Therapeutic Foster Care contract requires that annually TFC families complete no less than twenty eight (28) hours of post-licensing training per year. At least 80% of those TFC training hours (i.e., 22.4 hours) are to directly pertain to enhancing the clinical knowledge, skills and expertise of the foster families. At least 12 of those 22.4 hours must be training specific to the clinical presentation and/or diagnosis of the individual child(ren) in the home.

Data from site visits over the past 18 months, reviewing 12 of 16 TFC agencies, indicated that Therapeutic Foster Parents met a 100% compliance rate for pre-service training and a 65% compliance rate for post-licensing training. The pre-service training requirements include 30 hours of TIPS MAPP (Trauma Informed Partnering for Safety and Permanence- Model Approach to Partnerships in Parenting) and 7 hours of child-specific training. Post-licensing training requirements are 28 hours annually. Therapeutic Foster Care agency staff met a 98% compliance rate in pre-service and a 97% compliance rate in post-service training requirements.

Therapeutic Foster Care agencies are required, per their Scope of Service, to submit annual foster parent and staff training plans. These plans are submitted to the designated program lead at the Department of Children and Families', Central Office. The plans are reviewed and discussed at site visits and provider meetings. Therapeutic Foster Care agencies track foster parent and staff training schedules, attendance

and compliance internally via different tracking mechanisms, such as excel or Access database. A standardized tracking system may offer more consistency with data entry across TFC agencies and this has been considered. The new Pro Profs online training and tracking system may offer an opportunity for greater accessibility and agency tracking. It should also be noted that a, "provider portal" is currently a priority in the Department's new CCWIS project plan. TFC agencies recognize the need for a higher compliance rate and several agencies have reported that corrective action plans are in place for foster parents who are not compliance with post-licensing training expectations.

Training requirements are different for our relative caregivers who are only required to take nine (9) hours of pre-licensing training. This training is comprised of four (4) selected modules from the PRIDE curriculum. Regions maintain logs that capture the significant dates associated with licensure. The Department is currently in the process of reviewing and revising the relative training expectations. This will include the development of an electronic system to better capture the associated training completion data.



Foster parents licensed with the Department are required to participate in 6 modules of training annually post-licensing. There used to be two specific training topics required (5 and 6 – discipline and team member). Recently, that requirement was eliminated as both those topics are now fully discussed in the pre-licensing training. They continue to be available as a refresher option. The mandatory elements are now as follows: 1of the 6 mandatory modules must be in the area of trauma, 2) another module must be in the area of crisis intervention, and 3) every two years, foster parents must take a CPR certification class.

Trainings are available to foster parents in a variety of mediums. The most significant is through the Department's contracted partner CAFAP. They currently offer 28 different modules of which eight (8) are offered in Spanish. All modules can be delivered via use of an interpreter. Ten (10) of the modules are part of the PRIDE curriculum while the other 18 have been secured or developed by CAFAP. The calendar of offered sessions is rotated and developed based on communicated needs from each Area Office. CAFAP Liaisons in each AO will routinely communicate needed classes and ask for classes to be scheduled. The location and time of the training is also determined based on the needs of the families in the specific Area Office.

FASU Support Workers for the licensed families will make recommendations for needed training based on identified deficiencies in the family's skill set and/or specific to the needs of a child placed in their home. These workers visit their assigned families on a quarterly basis and will make routine recommendations at that time. Recommendations are also generated at times when concerns, often regulatory violations, are identified. These may include trainings around crisis management, effective discipline, and trauma-informed care.

Foster Parent training is an outcome measure reviewed under CT's *Juan F.* Consent Decree. The parameters guiding this measure are below:

Outcome Measure 13: Foster Parent Training [Back to Top]

Measure

Licensed DCF foster or pre-adoptive parents shall be offered 45 hours of post-licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. This measure does not apply to relative, special study or independently licensed foster parents for whom 8 hours of pre-service training is required.

Definitions

The Department will ensure that all modules requiring social worker attendance are attended by social workers. The Department will also hold training sessions near foster parents, offer daycare, night and weekend training sessions and other inducements to make it likely that foster parents can attend the training. Attendance at training will be a factor considered in licensure or re-licensure of foster parents.

Training shall be offered in the primary language of the foster parents.

Measurement Procedure

A. The Monitor shall determine if this outcome has been achieved through LINK quarterly reports. The percentage will be determined by averaging the three (3) months in each quarter. DCF will report quarterly on the barriers to meeting this measure.
B. The Monitor shall find that DCF has complied with this outcome measure when DCF has documented this outcome measure in LINK for two (2) consecutive quarters, maintains compliance through exit from this action, and the Monitor has verified compliance with this measure.

Data Mapping

Data from with respect to this outcome measure indicates that the Department has consistently achieved this requirement at a rate of 100%:

Statewide Juan F. Exit Plan Report Outcome Measure Overview

Measure	Measure	Base-line	Q3 2015	Q2 2015	Q1 2015	Q4 2014	Q3 2014	Q2 2014	Q1 2014	Q4 2013	Q3 2013	Q2 2013	Q1 2013
13: Foster Parent Training	100%	x	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

This measure and these data are reflective of the fact that Foster Parent Training is an area of review and scrutiny by the Federal Court Monitor and the *Juan F.* Plaintiffs. These entities have an interest in ensuring that the Department is making provision to offer foster parents a requisite number of training hour compliance opportunities. During 2015, 33% of foster and adoptive parents (excluding kin and special study families) were documented as participating in some post-licensing training. (See more in the Areas for Improvement section below.)

Next, a random sample of children ages 8 years or older, who were placed in a foster home, were invited to participate in a cross-sectional study. Data were collected through face-to-face interviews for 225 children and 221 caregivers (of which 12 secondary caregivers were excluded from the analysis); foster youth ages 13 years or older were also asked to complete a supplemental self-administered questionnaire to assess their pro-social and potentially detrimental behaviors. Descriptive statistics were used to examine the level of quality and satisfaction. Point in time data indicates that the number of surveyed families represent about 9% of core DCF, relative/kin and TFC licensed homes. Our sample of 221 foster homes gives us a Confidence Interval of 95% with a 6.3% Margin of Error. Therefore, we think these data are generalizable to the entire state.

Data below demonstrates that a high percentage of the survey foster parents think that the training addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children:

Table 6. Foster parents' perception of services received in the past year (N = 209)

Statement	n/N	Percent
Overall satisfaction with services received	163/206	79.1%
Intention to continue as a foster parent over the next three years	178/204	87.3%
DCF staff being courteous and friendly	198/208	95.2%
Trainings providing foster parent with needed knowledge and skills	177/200	88.5%
Trainings being scheduled at convenient time	152/196	77.6%
The child being matched well with the family	176/203	86.7%
DCF adequately assessing foster parents' needs on an ongoing basis	167/206	81.1%
DCF providing appropriate services to address identified needs	148/201	73.6%

The Department has a contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) that includes a range of support, education, training, and advocacy services to foster families, adoptive families and relative caregivers intended to address and meet their needs, encourage and facilitate ongoing education and skill development, and allow foster children to live in safe and stable home settings. Please see the attached Appendix to see the 2016 State Fiscal Year 2nd Quarter Report from CAFAP. That report well details the various training, support, retention and exit interview work and data that occurred during that period.

Last year (from July 1, 2014 to June 30 2015), CAFAP offered 174 different training opportunities for licensed foster parents. 1054 foster parents attended these trainings. In addition, the Department offers foster parents training through Foster Parent College, which is an online training portal. Foster parents are able to view trainings on their computers in their home. The Department purchases credits which can be assigned to individual foster parents. In SFY '15, 112 credits were utilized which represents 112 classes. The follow links to the various training that are offered to foster and adopted parents: http://www.cafap.com/our-services/training/training-module-registration/

http://www.cafap.com/our-services/training/

For therapeutic foster care, parent's training is tracked by their parent agencies. The Department engages in periodic random reviews during quality assurance site visits to assess each providers systems and make recommendations for improvements as may be warranted. At these site visits, foster parent records are reviewed to ensure that training hours are tracked and discussions ensue to provide support and consultation around tracking systems.

Staff at congregate care facilities are monitored by the Department's Licensing Unit for completion of mandatory training (e.g., CPR, first aid, ESI, mandated reporting). CT Regulation, codified in statute, sets forth the requirements for DCF licensed facilities. The link to these regulations is as follows:

http://www.ct.gov/dcf/cwp/view.asp?a=2639&Q=328878

Over the past year, DCF's licensing unit conducted 47 relicensing visits at child caring facilities (each facility must be relicensed every two years). During 13 of those visits, providers were cited for having at least one staff member who did not have evidence of the required trainings in their personnel file. On 8 occasions providers, were cited for missing CPR certifications, and on 9 occasions providers were cited for staff not having completed training on emergency safety interventions (restraint and seclusion). The most common scenario involved newly hired staff members (less than 2 months) who had not yet received the required training, or more senior staff who were late in receiving an annual update.

The Office of Children and Youth in Placement (OChYP) has begun to message to all congregate care providers the need for annual staff training plans. The plans would be submitted to the Department on an annual basis and feedback provided. This language has been added to the Scopes of the TGHs, but these amendments have not yet been executed

Areas for improvement: Currently pre- and post-testing are not utilized for any of the post licensing training. Evaluations are completed, but they only reflect satisfaction with the training and do not capture increased learning. An initiative is underway to translate some of the modules offered by CAFAP into webinars available on their website. The first will be available by the end of the year (2015) and 9 more are scheduled to be uploaded shortly thereafter. There are also efforts underway to translate these modules into Spanish. The webinars will include pre- and post-testing and a certificate of completion.

CAFAP conducts evaluations of the post-licensing training they coordinate. The feedback is shared with trainers and used to enhance future delivery of trainings, both logistics and content. CAFAP shares summarized findings with DCF in their Quarterly reports.

Further enhancements are underway specific to tracking and analysis of post-licensing training. A centralized hub is being developed for compiling data on all completed post-licensing training. Currently, this information is stored in two different systems. Once we move to this new system, we'll not only have a more complete sense of all completed trainings, but can also track better the percentage of foster parents who are in or out of compliance with established requirements.

The Department is also ramping up messaging with foster parents to reiterate the expectation for post-licensing training. A letter from the Commissioner outlining the requirements was forwarded to foster and adoptive parents that also conveyed the supports available to assist in achieving the requirement and the consequences for not doing so which could include no further placements and the need for an individualized training support plan. See letter from Commissioner: http://www.cafap.com/wp-content/uploads/2016/02/Post-licensing-training-letter-2016.pdf

Areas for improvement: Wait time until the prospective family can attend training varies across the State. In some Regions, families have to wait longer to attend a class depending primarily on the number of families waiting and the number of available trainers to conduct training. Systems are in place to address this, including better collaborations between Regions. For example, they include families from other Regions in training if it's conducive to the family (geography) and also between DCF and private provider agencies (Child Placing Agencies).

E. Service Array and Resource Development

Item 29: Array of Services

How well is the service array and resource development system functioning to ensure that the following array of services is accessible in all political jurisdictions covered by the CFSP?

- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.

Please provide relevant quantitative/qualitative data or information that show:

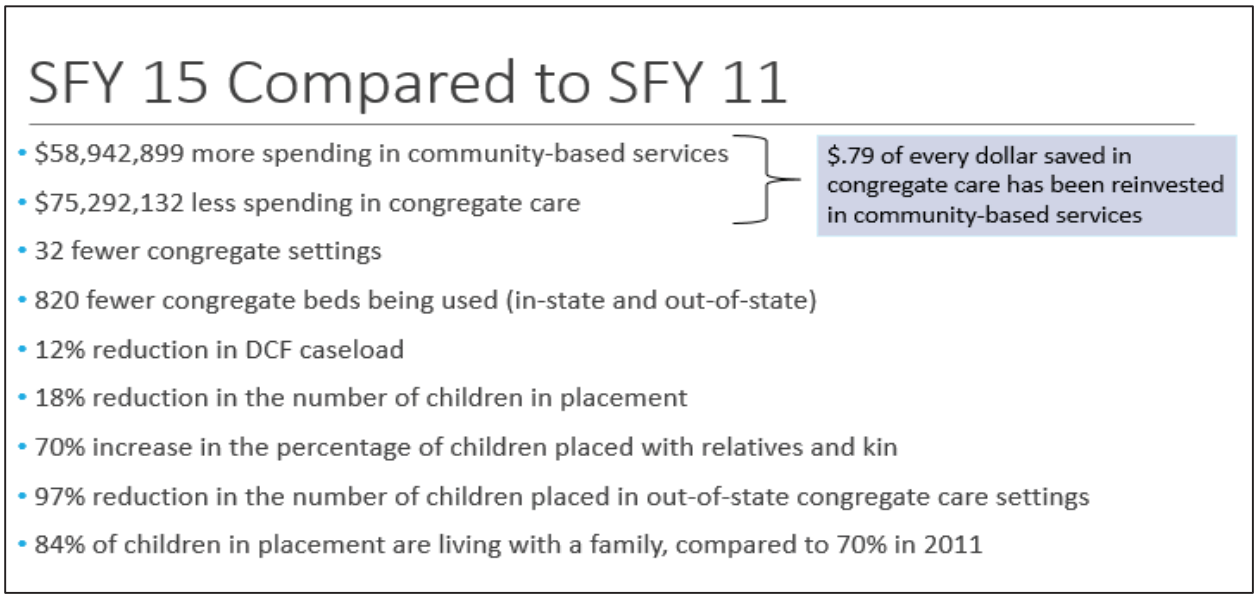
- The state has all the above-referenced services in each political jurisdiction covered by the CFSP;
- Any gaps in the above-referenced array of services in terms of accessibility of such services across all political jurisdictions covered by the CFSP.

State Response:

Connecticut's service array is coordinated through a committee that oversees the development of new services and the re-procurement process for existing services. The Service Array Review and Assessment (SARA) committee is responsible for ensuring every contract in Connecticut's child welfare service array has measurable child and family outcomes. SARA is also responsible for managing the procurement process, including approving Requests for Proposals and making decisions about how to invest our resources to improve the service array. The group meets every two weeks to review current services, modify existing scopes of service and make recommendations for the development of new services when gaps are identified in the state. It is chaired by the Chief of Quality and Planning the Deputy Commissioner who oversee fiscal and contracts. The SARA is also attended by the Commissioner, the other Deputy Commissioner, the Chief of Staff, Regional Administrators, the Director of the Academy for Workforce Development, the Director of Contracts, and the Director of Performance Management.

These meetings have been used, for example, to right size our investment in congregate versus community based services. Using forecasting and placement projections, the Department was able to determine that within the next year to two years, only 10% of the in care population will be in a congregate setting. Thus, there is a reduced need for congregate settings. This resulted in the closure in a number of congregate care settings. The Department has when possible, reinvested those dollars into community-based services. Please see below for a detailing of the shift from congregate care funding to increased community-based investment:

In addition, every month, Results Based Accountability (RBA) Report cards represented at least 4 difference DCF funded service types are presented at SARA. This supports the Department’s discussions



regarding possible gaps, needs and service efficacy. These Report Cards are updated every quarter by the DCF Program Leads. To date, 30 different RBA Report Cards have been presented to the SARA committee. In addition, some of the report cards are posted on the publically facing DCF website. A copy of the minutes from the SARA are attached as an Appendix. That document will help to explicate the extensive review of these reports cards that occurs at the SARA and how they are used. Generally speaking, the RBA report cards allow the Department's leadership to make data informed decision regarding service related funding matters. It allows the Department to not only assess the functioning and outcomes of a given service or similar types of services, but whether there is expected utilization and/or whether capacity is sufficient. It further allows the Department to discern whether there may be any gaps in services (statewide or regional) or gap in programming (i.e., summer programming for adolescents).

The service coordination process also involves considerable input from stakeholders at all levels. The Department hosts statewide service provider meetings to gather input from contracted and credentialed providers. We also meet regularly with the provider trade associations to discuss upcoming changes in the service array. Finally, the Department recently hosted a series of community forums to gather input from parents and other community members on the mental health services array.

In particular, in October 2014, the Department promulgated the Connecticut Children's Behavioral Health Plan. DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR, family advocates from the African Caribbean American Parents of Children with Disabilities (AFCAMP), and consultants from Yale University took lead roles in input-gathering activities, in partnership with CHDI staff. A Steering Team and a 36-member Advisory Committee oversaw the process. The core elements of the input-gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth;
- Open forums held in six locations and attended by 232 individuals;
- Facilitated discussions on 12 specific topic areas, attended by 220 individuals;
- Website input forms submitted by over 175 individuals and groups;
- A review of background documents and data pertaining to the children's behavioral health system in Connecticut.

The process yielded the identification of seven thematic areas that will result in significant improvements to the children's behavioral health service system in Connecticut:

A. System Organization, Financing and Accountability

B. Health Promotion, Prevention and Early Identification

C. Access to a Comprehensive Array of Services and Supports

D. Pediatric Primary Care and Behavioral Health Care Integration

E. Disparities in Access to Culturally Appropriate Care

F. Family and Youth Engagement

G. Workforce

The Plan presents a set of goals and strategies for each of the areas. The Plan may be accessed via the following link. The 2015 progress report, which details the enhancements made to Connecticut's system with respect to items A-G above, can be accessed via the following link.

SERVICES:

The below grid sets forth the various service contracts in which the Departments funds. For a detailed description of Connecticut's Service Array, including the geographic areas covered please see the Appendix.

Family Preservation	Family Support	Time-Limited Family Reunification	Adoption Support
Adopt A Social Worker	Adolescent Community Reinforcement Approach / Assertive Continuing Care (ACRA-ACC)	Adopt A Social Worker	Adopt A Social Worker
Care Management Entity (CME)	Adopt A Social Worker	Caregiver Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
Caregiver Support Team	Care Coordination	Community Targeted Re-Entry Pilot Program (CTRPP)	Community Support Team
Child Abuse Pediatricians (CAP)	Care Management Entity (CME)	Crisis Stabilization	Extended Day Treatment (EDT)
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Child Abuse Pediatricians (CAP)	Extended Day Treatment (EDT)	Family and Community Ties
Community Support for Families	Child First Consultation and Evaluation	High Risk Infant Program For Incarcerated Mothers	**Foster and Adoptive Parent Support Services**
Community Support Team	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	HOMEBUILDERS	Foster Care and Adoptive Family Support Groups
Community Transition Program	Community Based Life Skills	Intimate Partner Violence (IPV-FAIR)	**Foster Family Support**
Connecticut ACCESS Mental Health	Community Support for Families	**Multidimensional Treatment Foster Care**	Foster Parent Support for Medically Complex
Crisis Stabilization	Community Transition Program	Multidisciplinary Team	Fostering Responsibility, Education and Employment (F.R.E.E.)

EMPS - Crisis Intervention Service	Connecticut ACCESS Mental Health	New Haven Trauma Network	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS
Extended Day Treatment (EDT)	Crisis Stabilization	Outpatient Psychiatric Clinic for Children	Juvenile Sexual Treatment (JOTLAB
Family Based Recovery	Early Childhood Services - Child FIRST	Prison Transportation	Multidisciplinary Team
Fostering Responsibility, Education and Employment (F.R.E.E.)	Elm City Project Launch	Recovery Specialist Voluntary Program (RSVP)	New Haven Trauma Network
Functional Family Therapy (FFT)	EMPS - Crisis Intervention Service	Reunification and Therapeutic Family	Outpatient Psychiatric Clinic for Children
High Risk Infant Program	Extended Day Treatment (EDT)	Short Term Assessment and Respite Home	Permanency Placement Services Program (PPSP
High Risk Infant Program For Incarcerated Mothers	Family Based Recovery	Short-Term Family Integrated Treatment	Work To Learn Youth Program
HOMEBUILDERS	Family Support	Therapeutic Child Care	Zero to Three – Safe Babies
Intimate Partner Violence (IPV-FAIR)	Functional Family Therapy (FFT)	Therapeutic Foster Care (Medically Complex)	
Intensive Family Preservation	High Risk Infant Program	Zero to Three – Safe Babies	
Intensive In-Home Child and Adolescent Psychiatric Services IICAPS	Intimate Partner Violence (IPV-FAIR)		
Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE	Intensive In-Home Child and Adolescent Psychiatric Services IICAPS		
Juvenile Criminal Diversion	Intermediate Evaluation for Juvenile Justice Involved Children & Youth (IE		
Juvenile Review Board (JRB)	Juvenile Review Board (JRB)		
Juvenile Sexual Treatment (JOTLAB	Juvenile Sexual Treatment (JOTLAB		
Mental Health Consultation to Childcare	Mental Health Consultation to Childcare		
Modular Approach to Therapy For Children – MATCH	Modular Approach to Therapy For Children – MATCH		
Multidimensional Family Therapy (MDFT	**Multidimensional Treatment Foster Care**		
Multidisciplinary Examination (MDE) Clinic	Multidisciplinary Examination (MDE) Clinic		
Multidisciplinary Team	Multidisciplinary Team		
Multi-systemic Therapy (MST	Multi-systemic Therapy (MST)		
MST- Family Integrated Transitions	MST- Family Integrated Transitions		
MST - Building Stronger Families	MST - Building Stronger Families		
MST-Consultation and Evaluation	MST-Consultation and Evaluation		
MST - Problem Sexual Behavior	MST - Problem Sexual Behavior		
MST for Transition-Aged Youth	MST for Transition-Aged Youth		
New Haven Trauma Network	New Haven Trauma Network		
One on One Mentoring (OOMP)	One on One Mentoring (OOMP)		
Outpatient Psychiatric Clinic for Children	Outpatient Psychiatric Clinic for Children		
Parent Project	Parent Project		

Parenting Class	Parenting Class	
Performance Improvement Center	Performance Improvement Center	
Physical and Sexual Abuse Evaluation	Permanency Placement Services Program (PPSP)	
Positive Youth Development	Positive Youth Development	
Recovery Case Management (RCM)	Preparing Adolescents for Self-Sufficiency (PASS)	
Respite Care Services	Prison Transportation	
Sibling Connections Camp	Project SAFE	
Short Term Assessment and Respite Home	Recovery Case Management (RCM)	
Specialized Group Home with Behavioral Health and Support Services	Recovery Specialist Voluntary Program (RSVP)	
Statewide Family Organization	Residential Substance Abuse Treatment	
Therapeutic Child Care	Respite Care Services	
Therapeutic Foster Care (Medically Complex)	Reunification and Therapeutic Family	
Therapeutic Group Home	Sibling Connections Camp	
Triple P	Short Term Assessment and Respite Home	
Zero to Three – Safe Babies	Short-Term Family Integrated Treatment	
	Specialized Group Home with Behavioral Health and Support Services	
	Statewide Family Organization	
	Supportive Housing for Families	
	Supportive Work, Education & Transition Program (SWETP)	
	Therapeutic Child Care	
	Therapeutic Foster Care (Medically Complex)	
	Therapeutic Group Home	
	Triple P	
	Work To Learn Youth Program	
	Zero to Three – Safe Babies	

During a Statewide Provider meeting in April 2015, the Department had the regions and their providers break into groups to discuss their service area needs and strengths. These break out groups were facilitated by the Regional Administrators. Each group then reported out their discussions. A copy of the notes from that meeting are attached as an Appendix. All Statewide Provider meetings are attended by the Commissioner, all her Deputies, the Chief of Staff and the Chief of Quality and Planning.

RAs were asked to use the feedback from the Provider Meeting to bolster existing conversations in each of the Regional Advisory Councils. In addition, the information from the break out are be used to identify themes across the regions that need to be discussed at SARA. Further, the themes are also helping to

determine opportunities for Federal grant seeking and how we consider federal grant allocations in the upcoming federal fiscal year.

The Department has attempted to address some of the identified capacity and waitlist issues by funding these additional service expansions:

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Extended Day Treatment (EDT)
- Multi-Systemic Therapy for Transition Aged Youth (MST-TAY)
- Therapeutic Child Care
- IPV-FAIR (Intimate Partner Violence)
- Permanent Housing Vouchers
- Intensive Family Preservation (IFP)
- Adoption Assistance Program (AAP)
- Circle of Security (early childhood)
- Intervention program for DMST (Domestic Minor Sex Trafficking)
- Substance abuse Services
- Wendy's Wonderful Kids (targeted recruitment)

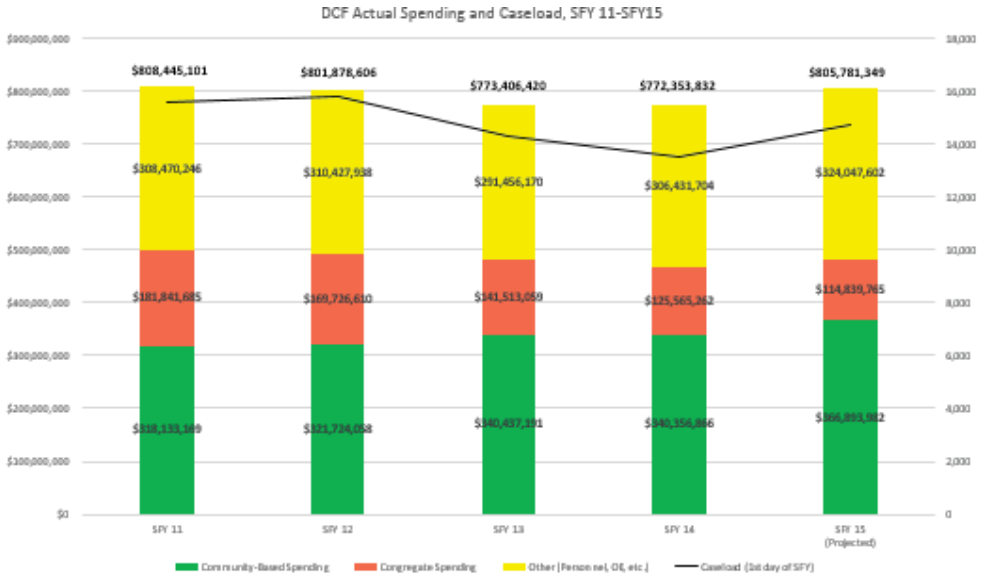
The below illustrates the investment the Department has been making to better support a sufficiency of community-based resources. Even with lower caseloads since 2011, the Department has increased investment in community services from $318 million in 2011 to $367 million in 2015

Item 30: Individualizing Services

How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be individualized to meet the unique needs of children and families served by the agency?

Please provide relevant quantitative/qualitative data or information that show whether the services in item 29 are individualized to meet the unique needs of children and families served by the agency.

- Services that are developmentally and/or culturally appropriate (including



linguistically competent), responsive to disability and special needs, or accessed

through flexible funding are examples of how the unique needs of children and families are met by the agency.

Region	Expenditures	Count of CSSA's
1	$ 404,212.85	10
2	$ 623,883.37	14
3	$ 661,319.89	16
4	$ 701,075.23	15
5	$ 1,242,169.99	27
6	$ 695,303.57	13
Grand Total	$ 4,327,964.90	91

State Response:

The Department employs a variety of mechanisms to support the individualized provision of services to children and families. For example, the Therapeutic Foster Care (TFC) contracts embed funding for Wraparound into the per diem rate. TFC also supports the provision of child specific service agreements to allow for care that is tailored to a child's individualized needs.

The determination of whether a child is eligible for TFC specific agreement is determined by their score on the Therapeutic Foster Care Eligibility Instrument (TEI). The TEI's algorithm converts scores into three categories: Higher than TFC; Eligible for TFC; Not Eligible for TFC (i.e., score suggests that Core foster care would be appropriate). For children who score at the top end of the TEI (i.e., Higher than TFC), if the Region and their clinical team think that a family setting is best and that this can be achieved through the use of individualized, wrap around services, a child specific agreement will be delivered. It should be noted that each DCF Region has a clinical team termed the Regional Resource Group (RRG) that is available to consult with the social work staff to support child specific planning and service provision. This consists of Clinical (Licensed) Social Workers; Substance Abuse Specialists, Education Specialists, Nurses, and an Intimate Partner Violence Specialist. They are supervised by a Clinical Program Director.

As was noted regarding Items 17 + 18, the Department requires that any child entering care receive a Multidisciplinary Evaluation (MDE). The assessments from these MDEs are generally reviewed by a member of the RRG. This allows them to assist the social work staff with best planning for and meeting the needs of the children served. Such assessment also support the development of child specific agreements, Unique Service Expenditure (USE) Plans (see below) and the purchase of individualized services using Wraparound funds.

For those youth, as noted above, who qualify for a child specific agreement, the Region is able to enter into them at their discretion. Such agreements are created by the regions using a template. They can and are to be signed off by the Area Office Director. As these are crafted and implemented locally, the Department does not think there are any issues with the functioning with respect to timeliness or statewide availability.

The below are data regarding the number of Child Specific Service Agreements (CSSA) that were in place during CY 2015. This $4 million is in addition to the $30 plus million the Department spends a year for TFC foster

The Department of Children and Families utilizes a variety of tools and resources to meet the needs of children and families in its care. Wraparound Funds, previously known as Flex(ible) Funds, are those resources that support essential services for children without which a child might be at risk for removal from his or her home, require a higher level of care or may not be able to return home to his or her family. As the name suggests, Wraparound Funds pay for goods and services that "wrap around" the child to meet his or her individualized needs. Occasionally, and with increasing regularity as the Department

continues to reduce out-of-home and out-of-state child placements, extraordinary services are needed to keep children in home settings with either their families, relatives or foster families. On these occasions, Unique Service Expenditure (USE) Plans may be developed to meet the individual needs of children.

Plans are developed when traditional or currently-available services are not sufficient to meet the child's/youths needs and expand the opportunities for children in DCF care, DCF staff are expected to consider new or expanded services that might increase the prospect of success for specific children. USE Plans are the mechanism through which exceptions to usual and customary spending patterns are authorized.

Thus, a USE plan is defined as: a document detailing services, including providers, objectives and estimated costs, related to those services provided to a child and his or her caregivers for the purpose of promoting growth and stability of a child who cannot be effectively served by current or traditional services and that would otherwise be unavailable. DCF Wraparound USE Funds are the funding source of last resort for all components of a USE Plan.

USE Process:

Eligibility: USE Plans may be developed for any of the following DCF populations (case must be open):

- Child Welfare;
- Juvenile Justice; and
- Voluntary Services.
-

Ages: A youth must be between the ages of 1-21 years old. An exception can be made for older youth in DCF care if a waiver is completed.

<u>General criteria for eligibility:</u>

- The youth must have a significant history of using multiple service types and have complex treatment and support needs that cannot be safely or effectively met by utilizing traditional services.
- The youth is at risk of disruption from a family placement or for children at risk of restrictive placements.
- The youth is not in a congregate setting long term, that is, the plan is used as a bridge to community or less restrictive settings (exceptions can be reviewed by a waiver process).
- To preserve treatment gains when stepping a youth down from congregate care to a community setting.
- There are no exclusions based on clinical or medical diagnoses.
- USE Plans shall demonstrate the need for unique services, increased intensity in services or an increase in duration of standard services.

- The USE plan must demonstrate a capacity for the family/caregivers to fully participate in the proposed services.
- The client(s) should generally demonstrate a capacity for growth in the area(s) of intervention along with the ability to eventually step down intensive/unique services.
- The Region must demonstrate that comprehensive planning has been completed at the Regional level, including resolution of any clinical, fiscal, legal or policy concerns prior to submitting the USE plan.
- DCF services supported by Wraparound USE Funds shall be considered only after all available sources of funding have been attempted or deemed by clinical staff to be inadequate.

Submission of USE plans

USE plans are created in each Region by various DCF staff involved in the youth's case. All USE plans must be approved by the Regional Administrator or their appointed designee (usually, the Clinical Program Director). Once the USE plan is approved at the Regional level, form DCF-3010, "Unique Service Expenditure Application, is e-mailed to the USE team at DCF-Central Office. Per USE policy, the USE team has up to two weeks to review the USE plan and put it on the weekly USE meeting agenda for review.

Emergency/Urgent Requests

In exceptional situations when the Regional Administrator (or designee) believes that a USE Plan requires more urgent attention, he or she may make a request to the USE Plan Review Team for a more rapid review of the USE Plan. The USE Plan Review Team, in consultation with the Deputy Commissioner for Administration and other staff as necessary, shall expedite such requests as determined necessary.

Review/Approval process

The USE team holds a pre-USE meeting every Monday at 10:30 a.m. to evaluate USE plans and USE reviews received by the Regions. The meeting is for the Central USE team to make recommendations or identify questions for the submitting region in preparing for the official USE meeting. The official USE meeting with the Regions occurs every Tuesday at 1 p.m. The Regions (if needed) call in to review the USE plans.

Once a USE plan is reviewed at the Tuesday meeting, the Central USE Team's makes final recommendations regarding each plan, the recommendations are sent to and reviewed with the DCF Deputy Commissioner for a final eligibility determination. At that point, the plan is either approved, denied, or a request for more information is made (i.e., placed on hold) by the Deputy Commissioner.

The Deputy Commissioner's decision regarding the Plan will go back to the USE Team in order to record the decision in the USE database and communicate the decision to the Regional Office (s).

USE Plan Rates

USE Plan rates shall be comparable to standard rates for contracted, fee-for-service or credentialed services or other state agency-established rates. When there is no rate available for a service, the USE team will work with the Area Office and/or Rate Setting to establish a state-wide rate.

Providers will only be paid from the start of the review date (or later) indicated on the approved USE plan (i.e. there is no backdating for USE services that begun prior to the approval of the USE plan).

USE Plans are approved for a specific period of time (not to exceed 1 year). If there is a need to continue a USE Plan beyond the approved time period, a new USE Plan needs to be submitted.

USE Plan monitoring

Region/AO	# of USE Plans	% of Grand Total
Region 1	**5**	**2.69%**
Bridgeport	4	2.15%
Norwalk	1	0.54%
Region 2	**22**	**11.83%**
Milford	14	7.53%
New Haven	8	4.30%
Region 3	**22**	**11.83%**
Middletown	2	1.08%
Norwich	14	7.53%
Willimantic	6	3.23%
Region 4	**43**	**23.12%**
Hartford	18	9.68%
Manchester	25	13.44%
Region 5	**19**	**10.22%**
Danbury	1	0.54%
Torrington	3	1.61%
Waterbury	15	8.06%
Region 6	**75**	**40.32%**
Meriden	20	10.75%
New Britain	55	29.57%
Grand Total	**186**	**100.00%**

Periodic review of USE Plans is essential because the Department must evaluate whether or not the unique services are meeting the individual needs of the child and, if they are not, what adjustments must be made to the USE Plan.

Periodic reviews are scheduled for each active USE Plan every 120 days or whenever the total budget for an individual USE Plan increases by more than 10%. Reviews may be scheduled more often at the direction of the Deputy Commissioner.

Regularly-scheduled USE Plan reviews are monitored by the USE Team. The USE review form (form DCF-3015) is completed by the appropriate Regional and submitted to the Central USE Plan Review Team. Review forms are approved by the Regional Administrator or designee prior to submission. Data from the reviews is maintained in the centralized database by the Central USE team.

USE Plan reviews include but are not limited to evaluations of updates to the initial goals, objectives and target outcomes (Qualitative and quantitative) as well as status ratings relative to the success of the overall USE Plan and provider satisfaction.

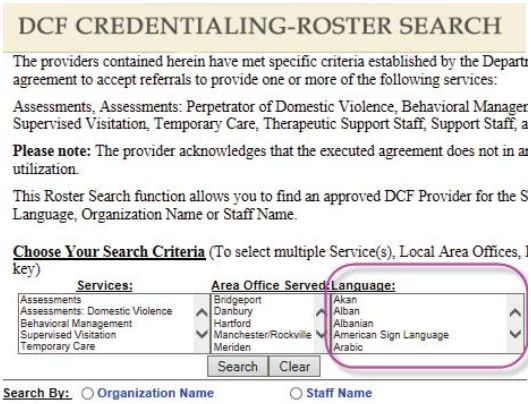
Billing

The Central USE team sends a complete list of all active USE plans to Fiscal on a weekly bases in order to assure that only providers working on approved USE plans are being paid for services. Also, approved USE plans are matched on a monthly to bi-monthly bases against WRAP expenditures to help the Regions identify WRAP (non-USE) expenditures that exceed $5,000/month to assess if a USE plan is needed for those individuals.

There were a total of 182 active USE plans between 1/1/2015 and 12/31/2015. This is an increase of 49 from last year (N= 133). Similarly, the Department approved over $4 million in USE Plans during CY 2015[14]. This is about a $1.4 increase in expenditures from last year

[14] The chart notes "Estimated Costs" as these data are noting the amounts/costs they were authorized. This is similar to the Medicaid authorization data versus claims data process.

Wrap dollars are also used by the Department to better support individualized servicing. For example, if a child has a specialized clinical or medical need that is not covered by Medicaid/HUSKY, that service or item can be purchased using the wraparound dollars. Wrap dollars are used for a plethora of services and supports as the below chart evidences (transportation, after school programming, camp, court fees, clinical support, security deposits, Youth Advisory Board stipends, etc.)


DCF CREDENTIALING-ROSTER SEARCH

The providers contained herein have met specific criteria established by the Departr agreement to accept referrals to provide one or more of the following services:

Assessments, Assessments: Perpetrator of Domestic Violence, Behavioral Manager Supervised Visitation, Temporary Care, Therapeutic Support Staff, Support Staff, a

Please note: The provider acknowledges that the executed agreement does not in ar utilization.

This Roster Search function allows you to find an approved DCF Provider for the S Language, Organization Name or Staff Name.

Choose Your Search Criteria (To select multiple Service(s), Local Area Offices, l key)

Services:	Area Office Served:	Language:
Assessments Assessments: Domestic Violence Behavioral Management Supervised Visitation Temporary Care	Bridgeport Danbury Hartford Manchester/Rockville Meriden	Akan Alban Albanian American Sign Language Arabic

Search Clear

Search By: ○ Organization Name ○ Staff Name

Region/AO	Sum of Estimated Costs	Average of Estimated Costs
Region 1	**$184,649.40**	**$36,929.88**
Bridgeport	$118,645.40	$29,661.35
Norwalk	$66,004.00	$66,004.00
Region 2	**$697,161.84**	**$31,689.17**
Milford	$564,005.34	$40,286.10
New Haven	$133,156.50	$16,644.56
Region 3	**$616,360.42**	**$28,016.38**
Middletown	$38,723.02	$19,361.51
Norwich	$405,394.60	$28,956.76
Willimantic	$172,242.80	$28,707.13
Region 4	**$938,156.75**	**$21,817.60**
Hartford	$468,330.65	$26,018.37
Manchester	$469,826.10	$18,793.04
Region 5	**$476,155.00**	**$25,060.79**
Danbury	$7,674.40	$7,674.40
Torrington	$59,180.40	$19,726.80
Waterbury	$409,300.20	$27,286.68
Region 6	**$1,330,584.19**	**$17,741.12**
Meriden	$356,961.52	$17,848.08
New Britain	$973,622.67	$17,702.23
Grand Total	**$4,243,067.60**	**$22,812.19**

Each region is given an annual wrap dollar allotment. They are able to use those dollars to purchase services, goods, programming, and other items needed to facilitate positive outcomes for a given child and/or family that the Region is serving. This may be used to purchase Credentialed Services or other non-categories needs that not available through our contracted service array, other state agency benefits, or Medicaid/HUSKY. The decision regarding how to use these funds rest with the Regions. Monthly usage reports are sent out to the Regions and the Commissioner's Office detailing the expenditures by Region and by category. There are also Grants and Contracts Specialists who are stationed in the Regions to aid with supporting the purchasing of approved items and assist with ensuring that the purchasing comports with Department and State policy and practice .

As of January 2016, the Department has spent $8,186,458 in wraparound services. This is in addition to the funds noted above for USE. The Annualized Expenses for SFY 2016 are $14,033,928, based on what has been spent SFY to date. The SFY 2016 caseload budget, however, is nearly $17 million. Each Region 1 has a caseload budget allocation. These range from about $2.3 million to $3.6 million. These funds can be used to purchase a variety of services that support children's and families individualized cultural and linguistic needs. In particular, our Credentialed Services array and process, which is funded using wrap dollars, supports provision of community-based care from local, culturally and linguistically competent service providers.

The Credentialed Services portal has an option by which services can be searched by a specific agency, staff person, community, and to support the language needs of our children and families

The agencies and providers who offer Credentialed Services tend to be more culturally, linguistically and linguistically diverse than the Departments contracted service agencies. The Department has a strong commitment to race justice. It is one of the Department's cross cutting themes. We have a broadly impaneled Statewide Racial Justice Workgroup. That body includes a Purchasing and Procurement subcommittee. The Department recently developed racial justice RFP language. Efforts are hoped to increase the diversity of our contracted provider pool and to ensure that all awarded agencies demonstrate the willingness and ability to competently serve clients across race, gender, ability, ethnicity, sexual orientation and language.

As an example, however, the below is information about one of the vendors in the Credentialed Provider portal from the Hartford Community. Such agencies are supporting the provision of culturally and linguistically competent services.

Finally, a copy of what DCF has actually spent in Wrap Funds during State Fiscal 2016 to January 16, 2016, is below. That tables also shows the array of individualized services and types funded via Wrap. Wrap dollars are used at the child level. This is an important distinction from our contract funding, which is purchased at a general service level. Thus, each specific wrap dollar is tied and can be matched to a specific child and/or family. The Department's estimated annualized Wrap expenditures for SFY 2016 are around $16 million. This is in addition to the $250 million the Department spends for contracted services. (See also Item 29).

***Proposed Racial Justice statement for use in all DCF Requests for Proposals (RFP):**

The Department of Children & Families is committed to ensuring that its service providers deliver effective, equitable, understandable, trauma informed and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, experiences of racism, preferred languages, health literacy, and other communication needs. Awarded contractors must demonstrate throughout all their responses, that the children and families receiving services in their program are approached, engaged and cared for in a culturally and linguistically competent manner, including but not limited to: Cultural identity, racial and/or ethnic, religious/spiritual ascription, gender, physical capability, cognitive level, sexual orientation, and linguistic needs. Within a broad construction of culture, service provision must also be tailored to age, diagnosis, developmental level, geographical and educational needs.

About My People Clinical Services

My People Clinical Services (MPCS) is a mission driven, community based social service organization established in the city of Hartford, CT in 2005 to "Support, Empower, and Rebuild" the lives of individuals and families in the Greater Hartford area. As a collective group of culturally competent and diverse professionals consisting of social workers, marriage and family therapists, parent educators, therapeutic support specialists, and professional human service practitioners we aim to advocate, empower, and strengthen the lives of all families behind the mission "To enable My People to help Your People so that Our People will succeed".

TX_SRVC_PMT	Region 1 Total	Region 2 Total	Region 3 Total	Region 4 Total	Region 5 Total	Region 6 Total	Area Office Grand Total
Camp-Adoption	$ -	$ -	$ -	$ -	$ 1,500.00	$ -	$ 1,500.00
Medical Treatment-Adoption	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Miscellaneous-Adoption	$ -	$ 1,096.00	$ 636.00	$ -	$ 901.25	$ -	$ 2,633.25
Respite Care-Adoption	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Miscellaneous-Subsidized Guardianship	$ -	$ -	$ -	$ -	$ 1,000.00	$ -	$ 1,000.00
Home Study Special Recruitment	$ -	$ -	$ 3,523.77	$ -	$ -	$ -	$ 3,523.77
Medical Treatment-Independent Living	$ (100.00)	$ 300.98	$ 176.90	$ 617.00	$ 1,619.60	$ 5,655.72	$ 8,270.20
Transportation-Independent Living	$ 81.00	$ 4,092.06	$ 3,883.77	$ 5,057.50	$ 3,799.40	$ 3,690.30	$ 20,604.03
Court Fees - In Home	$ 608.00	$ 1,186.75	$ 4,233.89	$ 2,786.77	$ 2,423.50	$ 4,697.58	$ 15,936.49
Meals/Lunches-In Home	$ 39.16	$ 37.78	$ 20.17	$ 21.30	$ 131.62	$ 233.91	$ 483.94
Miscellaneous-In Home	$ 16,905.70	$ 20,318.83	$ 9,736.18	$ 11,147.97	$ 13,993.74	$ 9,344.37	$ 81,446.79
Transportation Other-In Home	$ 19,844.89	$ -	$ 74,518.73	$ 3,331.84	$ 7,030.50	$ 1,918.66	$ 106,644.62
Miscellaneous-Foster Care-IJ	$ 293.98	$ 4,995.71	$ -	$ -	$ -	$ 4,746.97	$ 10,036.66
Camp-Foster Care	$ 46,119.88	$ 41,763.88	$ 74,610.22	$ 113,844.92	$ 78,434.23	$ 60,784.44	$ 415,557.57
Clothing,Initial-Foster Care	$ 200.00	$ 206.81	$ 287.15	$ 1,074.80	$ 49.99	$ 331.45	$ 2,150.20
Medical Treatment-Foster Care	$ 2,339.25	$ 275.00	$ 9,138.24	$ 56,261.31	$ 26,404.93	$ 4,096.80	$ 98,515.53
Medically Complex Respite Care-Foster	$ 4,530.00	$ 1,255.44	$ 1,092.00	$ 2,631.30	$ 3,233.70	$ 1,953.74	$ 14,696.18
Miscellaneous-Foster Care-CPS	$ 52,467.76	$ 135,060.41	$ 113,774.14	$ 91,137.36	$ 337,642.16	$ 63,667.72	$ 793,749.55
Respite Care-Foster Care CPS	$ 16,363.65	$ 12,774.95	$ 24,750.65	$ 20,790.87	$ 21,864.50	$ 17,922.74	$ 114,467.36
Transportation Home-Foster Care CPS	$ -	$ 602.24	$ 1,557.32	$ 6,298.36	$ 7,290.27	$ 14,855.79	$ 30,603.98
Transportation Other-Foster care CPS	$ 38,471.03	$ 206,684.68	$ 146,053.84	$ 284,181.86	$ 258,541.07	$ 35,861.27	$ 969,793.75
Miscellaneous-Foster Care-MH	$ 525.00	$ -	$ -	$ -	$ 2,650.00	$ -	$ 3,175.00
Medically Complex -Extraordinary Expense	$ -	$ 2,590.38	$ -	$ -	$ -	$ 11,147.38	$ 13,737.76
Youth Advisory Board Stipend	$ -	$ 2,270.70	$ 2,680.00	$ -	$ 80.00	$ 560.00	$ 5,590.70
Sibling Visitation	$ 484.09	$ 375.47	$ 5,077.71	$ 866.79	$ 10,288.33	$ 65.64	$ 17,158.03
Assessment - Foster Care	$ 4,500.00	$ 12,781.25	$ 24,893.50	$ 10,642.50	$ 28,787.42	$ 10,986.00	$ 92,590.67
Behavior Management Foster Care	$ 4,739.50	$ 3,970.20	$ 2,396.50	$ 12,406.53	$ 9,160.21	$ 24,432.48	$ 57,105.42
Case Management Foster Care	$ -	$ 1,151.10	$ -	$ 8,848.50	$ -	$ 4,025.00	$ 14,024.60
Supervised Visits - Foster Care	$ 10,743.75	$ 85,051.27	$ 300,364.90	$ 24,035.90	$ 77,313.03	$ 138,068.93	$ 635,577.78
Therapeutic Support Staff - Foster	$ 120,374.47	$ 115,410.94	$ 186,575.06	$ 116,405.38	$ 113,834.92	$ 89,396.35	$ 741,997.12
Behavioral Health Services - Foster	$ 55,093.66	$ 4,725.00	$ 17,561.18	$ 35,188.20	$ 47,239.15	$ 16,713.87	$ 176,521.06
Temporary Care Service Foster Care	$ -	$ -	$ -	$ 46,964.00	$ 1,716.00	$ 250.00	$ 48,930.00
Support Staff Foster Care	$ 8,495.46	$ 47,180.64	$ 38,902.50	$ 22,895.75	$ 70,824.95	$ 14,683.73	$ 202,983.03
After School Srvs, Trdtnl grde K-8	$ 6,921.00	$ 5,068.97	$ 4,018.00	$ 8,248.02	$ 11,079.90	$ 5,852.20	$ 41,188.09
After School Srvs, Youth grdes 9-12	$ 1,059.00	$ -	$ 1,950.00	$ 4,036.00	$ 3,473.28	$ 1,014.00	$ 11,532.28
After School Srvs, Clinical Suprt K-8	$ 15,045.00	$ -	$ 600.00	$ 12,137.00	$ 5,165.00	$ 2,025.66	$ 34,972.66
After School Srvs, Clincal Suprt 9-12	$ 472.00	$ -	$ 3,600.00	$ 136,812.00	$ 311.52	$ 472.00	$ 141,667.52
Psych/Neuropsych Evaluation	$ -	$ 8,060.00	$ -	$ -	$ 750.00	$ -	$ 8,810.00
Camp-In Home	$ 31,341.50	$ 9,382.00	$ 86,247.00	$ 15,277.00	$ 24,136.00	$ 6,153.83	$ 172,537.33
DayCare-In Home	$ 1,390.00	$ 125,089.82	$ 44,824.60	$ 20,122.00	$ 48,071.40	$ 18,625.43	$ 258,123.25
Medical Treatment-General Health In Home	$ 3,304.00	$ -	$ 140.00	$ 1,747.05	$ 712.50	$ 176.00	$ 6,079.55
Temporary Care Services -In Home	$ -	$ -	$ -	$ 2,520.00	$ -	$ 1,728.00	$ 4,248.00
Furniture	$ 6,577.00	$ 1,428.51	$ 1,682.36	$ 1,258.00	$ -	$ -	$ 10,945.87
Rental Assistance - In Home	$ 31,997.80	$ 26,189.20	$ 17,792.91	$ 62,908.34	$ 25,544.00	$ 27,022.90	$ 191,455.15
Utilities	$ 13,488.13	$ 25,125.10	$ 6,527.46	$ 9,795.03	$ 3,465.14	$ 6,578.46	$ 64,979.32
Medical Treatment-BehaviorHealth In Home	$ 7,033.55	$ -	$ 5,538.68	$ 5,926.30	$ 23,167.00	$ 1,637.50	$ 43,303.03
Assessment, In Home	$ 6,325.00	$ 4,565.00	$ 7,052.40	$ 9,792.50	$ 23,906.70	$ 1,950.00	$ 53,591.60
Behavior Management In-Home	$ 3,516.80	$ 777.40	$ 64,145.85	$ 22,869.20	$ 4,893.50	$ 4,899.20	$ 101,101.95
Case Management In Home	$ -	$ -	$ -	$ 2,621.10	$ -	$ 1,275.00	$ 3,896.10
Other Family Supports	$ 132,199.77	$ 72,471.19	$ 151,954.91	$ 168,578.11	$ 175,911.98	$ 94,559.02	$ 795,674.98
Supervised Visit In-Home	$ -	$ 535.71	$ 236.25	$ -	$ -	$ 3,173.83	$ 3,945.79
Therapeutic Support Staff In-Home	$ 91,423.74	$ 41,976.67	$ 153,481.50	$ 54,175.00	$ 61,210.00	$ 27,207.15	$ 429,474.06
Support Staff In-Home	$ 3,516.78	$ 3,600.59	$ 52,796.00	$ 13,196.25	$ 60,468.55	$ 802.50	$ 134,380.67
Extended Credentialed Services-USE	$ -	$ 7,906.00	$ 71,470.20	$ 6,480.00	$ 158,958.54	$ 70,757.63	$ 315,572.37
Assessment & Planning for USE	$ -	$ 1,722.50	$ -	$ 1,000.00	$ 3,036.30	$ 11,462.93	$ 17,221.73
Intensive IndividualSupport for USE	$ -	$ 14,795.74	$ -	$ 42,658.18	$ 48,555.95	$ 34,859.75	$ 140,869.62
Extended Contract Services-USE	$ -	$ 5,850.00	$ 7,862.50	$ -	$ 8,715.00	$ 650.00	$ 23,077.50
Difficulty of Care Payment for USE Class	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other Services USE	$ 58,041.92	$ 90,685.19	$ 1,236.50	$ 117,705.40	$ 8,036.95	$ 23,581.44	$ 299,287.40
After School Srvs, Traditional grde 9-12	$ 762.00	$ -	$ 1,040.00	$ -	$ -	$ -	$ 1,802.00
After School Srvs, Youth grades K-8	$ 1,535.00	$ 235.00	$ 150.00	$ 700.00	$ 3,557.00	$ 1,976.00	$ 8,153.00
After Schl Srvs, Clinical suprt K-8	$ 17,405.00	$ -	$ 2,550.00	$ -	$ -	$ -	$ 19,955.00
After Schol Srvs Clinical suprt 9-12	$ 3,304.00	$ -	$ -	$ 944.00	$ -	$ -	$ 4,248.00
Security deposit In Home	$ 15,700.00	$ 29,103.00	$ 23,680.00	$ 35,262.10	$ 26,545.00	$ 18,660.00	$ 148,950.10
Chaffee Reimbursement for YAB Stipend (#587)	$ -	$ (2,270.70)	$ (2,680.00)	$ -	$ (80.00)	$ (560.00)	$ (5,590.70
SFY 2016 as of January 2016	$ 855,479.22	$ 1,178,455.36	$ 1,754,341.44	$ 1,634,205.29	$ 1,857,345.68	$ 906,631.27	$ 8,186,458.26

F. Agency Responsiveness to the Community

Item 31: State Engagement and Consultation With Stakeholders Pursuant to CFSP and APSR

How well is the agency responsiveness to the community system functioning statewide to ensure that in implementing the provisions of the CFSP and developing related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

> Please provide relevant quantitative/qualitative data or information that show that in implementing the provisions of the CFSP and related APSRs, the state engages in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP.

State Response:

As known, the Connecticut Department of Children and Families is a consolidated child welfare agency having legislative mandates with respect to children protection, children's behavioral health (i.e., mental health and substance abuse), prevention, juvenile justice and its own school district. Under these mandates, the activities of the Department are integrative and reflective of a number of key priorities and foci that extend beyond what may be a traditional child protective services lens. These mandates also require the Department to contextualize and conceptualize its APSR and CFSP within those broader responsibilities and the attending activities, including those that emanate from a variety of other state and federal statutory and reporting expectations. This is the backdrop in which the Department broadly engages and consults with and responds to stakeholders and the community.

A current example pertains to the closure of the Connecticut Juvenile Training School (CJTS) by July 1, 2018, a goal set by Governor Dannel P. Malloy. The Department is developing recommendations for changes in the juvenile justice system. The plan is being created to provide for the best interests of the youth currently at CJTS or who in the future would be served there if the age of youth in the juvenile justice system is raised once again. This process is receiving direct advice from the Juvenile Justice Policy and Oversight Committee (JJPOC). The JJPOC is a legislatively created body "established to evaluate policies related to the Juvenile Justice system and the expansion of juvenile jurisdiction to include persons sixteen and seventeen years of age. " It is chaired by a Legislator and the secretary of the CT Office of Policy and Management.

DCF Deputy Commissioner Fernando Muniz is helming this effort. In addition to receipt of advice from the JJPOC, he is meeting with a variety of stakeholders to get input into the plan for closure. In particular, Deputy Muniz presented at the last DCF Statewide Advisory Council (SAC) meeting (March 7, 2016) to elicit their thoughts and recommendations regarding the plan to close CJTS. Another example of the

Department's outreach to communities regarding this effort can be observed through the link to a recent NPR article about this effort.

In addition, an external facing webpage has been created to inform interested persons about the work occurring to close CJTS and re-define CT's juvenile justice system. In particular, that site noted that "All stakeholders are welcome to submit their recommendations on the closure and on what services are needed in communities to serve this population of youth by sending an e-mail to CJTSPlan@ct.gov." This website may be visited by accessing the following link.

As the above indicates, the Department continues to recognize the value and importance of collaboration and consultation with the community to improve outcomes for children, youth and families. Therefore, the Department has established and participates in a variety of opportunities to partner with key stakeholders. For example, families and consumers participate in reviewing bidder proposals for new or re-procured programs and services, learning collaboratives such as the family engagement and TF-CBT collaboratives for outpatient clinics, and various committees to evaluate programs, develop new services and initiatives, and implement plans.

Some advisory bodies that serve as critical partners include the following:

a) State Advisory Council (SAC): This seventeen-member council was established through legislation to assist the Department through input into each of the Department's mandated areas of responsibility, including children's behavioral health. The Council recommends, to the Commissioner, programs, legislation or other matters which will improve services for children, youth and their families served by the Department. The SAC assists in the development of, review and comment on the strategic plan for the Department. The SAC reviews quarterly status reports on the plan, independently monitors progress and offers an outside perspective to the Agency. The SAC also serves as one of three Citizen Review Panels in CT.

b) Children's Behavioral Health Advisory Committee (CBHAC): Established by Public Act 00-188, CBHAC's charge is to promote and enhance the provision of behavioral health services for all children in the state of Connecticut. The Committee oversees the Community Services Mental Health Block Grant including the overall design and functioning of the statewide children's system of care. The committee evaluates and submits an annual report on the status of the local systems of care, the status of the practice standards for each service type, and submits recommendations to the SAC on Children and Families. CBHAC members also actively participate in the CT Joint Behavioral Health Block Grant Planning Council, which is co-chaired by a children's representative. CBHAC has 32 voting members, 16 of whom are family members and/or caregivers and all committees strive to include at least 50% family members and/or caregivers.

c) Youth Advisory Boards: DCF staffs also work in partnership with and solicit input from the Youth Advisory Boards from each of the local area offices and a statewide Youth Advisory Board. Approximately 50 youth in "out-of-home care" participates.

d) Citizen Review Panel Support: There are a number of parent advocacy groups in the state that are designed to review Department practices specifically in the areas of behavioral health. FAVOR is a statewide Family Advocacy Organization for Children's Mental Health. Their mission is to enhance mental health services for children with serious emotional disorders by increasing the availability, accessibility, cultural competence and quality of mental health services for children through family advocacy. This

organization agreed to broaden their focus and responsibilities and function as two of Connecticut's three Citizen Review Panels. In order to support and encourage parental participation, the Department has agreed to allocate funding for members to receive stipends for transportation and daycare costs, as well as to assist FAVOR for associated meeting costs. The Executive Director of FAVOR continues to facilitate and coordinate meetings and oversee the work produced by the panels.

e) Connecticut Community Providers Association (CCPA)[i]: This member-based organization represents providers of services for children with mental illness, substance abuse disorders and other disabilities and special needs. The mission is to achieve service system change, represent the voices of its members at the state and local levels, and support the delivery of high quality, efficient and effective services.

f) The Connecticut Suicide Advisory Board (CTSAB): This body is co-chaired by DCF and DMHAS is a diverse, collaborative network of over 250 people and 100 agencies representing advocates, educators, leaders, and survivors concerned with advancing and sustaining efforts to eliminate suicide across the life span. The state of Connecticut Suicide Prevention Plan 2020 was issued in December 2014 and officially released as part of National Suicide Prevention Week in September 2015. A copy of that plan can be accessed via the following link.

g) Connecticut Juvenile Training School (CJTS) Advisory Board (CJTSAB): Pursuant to CT General Statutes Section 17a-6, the purpose of the CJTSAB shall be to provide an ongoing review of the CT Juvenile Training School and to advise the Commissioner of the Department of Children and Families with recommendation for improvement and enhancement. Opportunity for feedback and comment are a standing item on the CJTSAB agenda. Efforts also are made to solicit members input on various plans, policies and initiatives being promulgated by CJTS. These include but are not limited to the 2015-2016 Operational Strategies, the Length of Stay protocol and the annual CJTS Report. Evidence of this these outreach activities can be observed in the CJTSAB minutes.

This body's bylaws require that the CJTSAB shall consist of no more than 15 voting members and 5 ex-officio members. Members shall be persons interested in the field of juvenile justice, including but not limited to state legislators, private providers of human services, advocates in the field of social services, a former resident of CJTS and the residents of the surrounding geographic area of CJTS. Attempts are also to be made to include a parent representative or guardian of a current or former CJTS resident on the CJTSAB. Copies of the CJTSAB meeting agendas and minutes can be accessed via the following link.

For a complete listing of the various statutorily created bodies that advise the Department and others on which the Department has representation, please access the following link.

As noted above, the Department receives community input from a number of statewide and local advisory councils. At the statewide level, the State Advisory Council (SAC) is a 17-member council appointed by the Governor to advise the Commissioner on matters pertaining to services for children and families. The Department also receives significant input from a statewide Children's Behavioral Health Advisory Council (CBHAC), local Regional Advisory Councils (RACs) affiliated with each of our six regions, advisory councils at each of our facilities, the Citizen Review Plans, and Youth Advisory Boards (YAB).

The Department has a strong network of Youth Advisory Boards (YABs) that operate in each of its six regions. The YABs are comprised of young people in the Department's care who meet on a regular basis to provide feedback and recommendations about DCF's service array and practices. Representatives from the regional YABs convene quarterly at a statewide meeting with senior leaders at the Department, including the Commissioner. In order to encourage, limit barriers and facilitate youth participation in Youth Advisory Boards, stipends are distributed to youth who serve on the YABs. The YAB lead development of the State of Connecticut Adolescents in Care Bill of Rights and Expectations. That document was approved by them and adopted by DCF in June 2015. That document may be viewed by clicking on the following link.

Next, the Department has been supporting Community Collaboratives designed to recruit, strengthen and support neighborhood-based culturally competent foster/adoptive resources for children for many years. Collaboratives have been established to serve all the Area Offices and are responsible for engaging new partners to broaden community ownership for planning and implementing activities that recruit and support foster and adoptive families. Funds are distributed through a fiduciary (Advanced Behavioral Health) and used to support meeting costs, planning efforts and activities implemented by the collaborative for the purpose of recruiting and retaining foster and adoptive families.

These activities may include, but are not limited to: special family events, appreciation dinners, media/advertising, promotional items, brochure development and printing, program supplies and training. Each Collaborative has an executive board that provides support and direction to the collaborative. A staff person from the Department's Area Office foster care unit leads the Community Collaboratives and meets with the coordinators bi-weekly and approves all financial reimbursements. The coordinator from each collaborative maintains contact with families from the date of inquiry up to licensing or withdrawal and gathers information about their decision to withdraw.

DCF also collaborates closely with both the Department of Mental Health and Addiction Services (DMHAS) and the Department of Developmental Services (DDS). DCF, in conjunction with DMHAS and DDS, has developed a significant number of protocols and processes to support transition planning and collaboration. These apply to youth aging out of foster care as well as those involved in other parts of the DCF system (Voluntary Services, Juvenile Justice, In-home services, etc.).

DMHAS offers a specialized Young Adult Services program (YAS) for 18-25 year olds aging out of the DCF system who have significant psychiatric disabilities and who will need services and supports when they leave the children's system. DMHAS also has an array of adult mental health services but most of the youth who meet the program criteria and are identified with needs go directly to the specialized YAS program. DCF refers between 200 and 300 youth to DMHAS each year. These referrals are made at age 16 unless the youth enters care later. DMHAS cannot start services until age 18. DCF transitions an average of 110 youth to DMHAS each year between the ages of 18 and 21.

DDS works with individuals who have developmental disabilities and are likely to need support and services throughout their lifetime. DDS has an array of services and has been able to target resources, which are not available to the general public, specifically to youth aging out of DCF. As of May 2015, DCF has identified 201 children/adolescents who have been referred to and made eligible for DDS and who will eventually transition to adult services, typically at age 21. DCF and DDS maintain a “shared client list”

which is updated regularly to assure that DCF involved youth are identified, referred and transitioned. DCF has been tracking transitions to DDS since SFY 2011, and an average of 73 youth per year have transitioned to DDS.

DDS also has a program for children and adults on the autism spectrum (ASD) but who do not have intellectual disabilities (ID). The program has a limited number of slots and only 50 for children. In FY 13 and 14, DCF transitioned 36 youth to this program. In addition, DCF maintains a list of eligible youth for transition when space is available. The waiting list for these services is anticipated to be reduced over time with the implementation of the state's Medicaid coverage for children with ASD up to age 21 which give some families another option for services.

At the local level, DCF Area Offices have monthly, bimonthly and quarterly meetings with DMHAS and DDS staff. For example, DMHAS Young Adult Services staff plus representatives from their local YAS Programs meet with DCF Area Office staff to discuss individuals who have been referred to DMHAS and are in need of or already in the process of transitioning; they address any issues that impact transition and identify problems or resource needs that impede smooth and timely transitions. DDS Regional Office staff also meet with DCF local Area Office and Central Office staff to review and track youth transitioning from DCF to DDS. The purpose of the meeting is to identify who is transitioning, what is the transition plan and the timing, who is involved and if there are barriers that need to be addressed.

At the administrative level, bi-monthly meetings are convened to assure that systems issues and barriers that cannot be resolved at the local level have a forum in which to be discussed and addressed. An example of a collaboration project that involved a variety of stakeholders is Life Skills preparation. DCF and DMHAS have been working together for a number of years to identify ways to better prepare youth for adult roles and responsibilities. DMHAS provided feedback that many of the youth, coming from both foster care and congregate care settings, had few, if any practical skills to prepare them for community living.

DCF and DMHAS used a pilot project in one Area Office (New Britain) around both better transition planning and improving life skills. The collaboration brought together DCF, DMHAS, community provider staff as well as youth who had already transitioned to DMHAS and could provide feedback on what did/did not work. To look at the area of life skills, DMHAS also included Occupational Therapists with special training in assessing and teaching skills to young adults with psychiatric disabilities. A specific assessment tool (Learning Inventory of Skills Training – LIST) was developed and piloted and is now being expanded statewide for use with all DCF adolescents - both DMHAS and non-DMHAS bound.

Further, since 1995 DCF and The Connecticut Association of Foster and Adoptive Parents have engaged in a partnership benefiting thousands of children and families. The Connecticut

Association of Foster and Adoptive Parents makes a difference in the lives of foster, adoptive and relative caregivers by providing support, training, and advocacy. They receive an average of 150 inquiries to the KidHero line a month. There are currently about 2000 DCF licensed families; CAFAP provides support to all DCF licensed families.

Beginning in 2014, CAFAP partnered with DCF on several initiatives including a foster care satisfaction survey, health and wellness initiative, increasing foster parent participation in post-licensing training and increasing the number of families/individuals who inquire about becoming foster parents. CAFAP has increased the ability of their KidHero inquiry process to track how an individual became aware of the need for foster parents and maintains contact with the inquirer until he or she can attend an open house. CAFAP has begun sending monthly KidHero inquiry reports to every region and compiles this information on a quarterly and annual basis.

CAFAP has been very responsive to the increasing focus on placing children with kinship families and in maintaining those placements through the services of the CAFAP liaisons.

Each DCF Office has a CAFAP liaison working with the local Foster Care units to help maintain the placement, provide services to the foster family and child(ren) and to collaborate with DCF on achieving permanency. In 2015-2016 we expect to see the partnership with CAFAP continue to grow. One new area of focus is on CAFAP developing a new online training system for post-licensing trainings. This system will enable foster parents to complete post-licensing modules from any computer with Internet access and not have to travel to a training. Hopefully this will increase the completion rate of post-licensing trainings for foster parents. CAFAP is also exploring purchasing an online LMS system that will aggregate these module results and report to CAFAP and DCF what modules are being completed and where improvements in the system are needed.

In addition, DCF has engaged in a variety of collaborative efforts with the Judicial Branch and its partners in an effort to meet the various mandates, goals and objectives to assist individual and systemic improvements to the lives of children and families in CT.

Some examples are as follows:

1. As a member of the Court Improvement Project (CIP), DCF continues to collaborate with the Judicial Branch, Office of the Chief Public Defender, Department of Education, Office of the Child Advocate and others to develop strategies and processes for encouraging the Juvenile Court to play a more active role in the educational outcomes of committed children. DCF participated in a statewide video training that was broadcast live to all the Juvenile Courts where judges, lawyers, court personnel and DCF educational specialists were able to interact with the presenters and the audience in other courts. The focus of the training was an overview of how courts, lawyers and DCF can advocate for the educational needs of children.

2. DCF completed a project with DDS, DAS and DPH to streamline the licensing process for community based non-profits who provide congregate care services to children and adults. The collaboration has resulted in a uniform license application, online filing of applications to each agency, and reduction of duplication for providers seeking licenses from more than one state agency.

3. The RSVP program, a collaboration between DCF, DMHAS and the Judicial Branch that provides recovery case managers to parents who have lost custody of children through an OTC due to substance use has expanded to the Manchester office and Rockville court and the Norwich office and Waterford court. In addition, the RSVP core team has coordinated training in substance use related areas for court personnel and lawyers who practice in Juvenile Court.

4. As a result of new federal and state legislation, DCF, the Office of the Attorney

General and the Juvenile Court collaborated to create new forms and a new procedure for continuing court review of cases involving youth who reach the age of 18 and voluntarily remain in DCF care. The collaboration resulted in a process that permits the state to continue to claim Title IV-E reimbursement for these youth.

5. DCF, the Juvenile Court are working on initiatives to track and reduce recidivism among youth in the juvenile justice system.

6. A partnership among Connecticut's Department of Children and Families (DCF), the Child Protection (CP) division of the Superior Court for Juvenile Matters, and the Court Support Services Division (CSSD) of the Juvenile Branch was formed to share data on youth served in their respective agencies. This resulted in a data set of 7,268 DCF-involved youth, 1,207 (16.6%) of whom had subsequent juvenile justice contact. This dataset was then provided to the University of Connecticut Center for Applied Research in Human Development (CARHD) for analysis.

As noted in the recent CT CrossOver Youth Research Brief, "the partners are planning next steps for data analysis, including looking at how youth with "deep involvement" in child welfare become involved in juvenile justice compared to youth without a history of maltreatment. Additionally, efforts are being made to engage other systems that serve these youth, including mental health, education, and homeless supports. This information can be put to use in identifying youth at increased risk of crossing over and developing prevention efforts. The ongoing work of this project aims to inform how systems can better coordinate with one another to better serve some of the most vulnerable youth in our state, and in the nation."

For over 15 years, the CT Head Start State Collaborative Office (HSSCO) has staffed, funded and co-convened this valuable collaboration to work better together in support of families. DCF and Head Start staff from the 14 local DCF Area teams from across the state come together quarterly with their key partners, ECCP and Supportive Housing for

Families, and more recently Part C/Birth to Three and Child First, to strengthen their understanding of the various programs and foster working relationships to better support families. An Early Childhood Child Welfare federal grant infused Strengthening Families and Infant Mental Health into practice with families.

Next a Parents With Cognitive Limitations Workgroup was formed in 2002 to address the issue of support of parents with cognitive limitations and their families. Members include all of the major human services state agencies (Department of Children and Families is the lead; other state members include:

> Departments of Correction; Housing; Social Services; Developmental Services; Public Health; Mental Health & Addiction Services, Office of Early Childhood) as well as a diversity of private providers.

Although the number of families headed by a parent with cognitive limitations is uncertain, and identification of these families is one of the group's challenges, it is estimated that at least one third of the families in the current child welfare system are families headed by a parent with cognitive limitations. These parents may be unidentified or may be misidentified as mentally ill or as substance abusers. When

they cannot meet the expectations of the available programs and services, including those designed for these other populations, these parents are often labeled as "noncompliant", or "uncooperative."

This population needs to be recognized as distinctive and in need of specific services tailored to its needs. Currently, there are few community supports tailored to meet the ongoing needs of these families who often require longer term services than most of our systems currently fund. In addition, many of our systems fund services for an individual (e.g., child or substance abusing parent) but not for the family.

To address these issues, The Workgroup developed a training on "Identifying and Working with Parents with Cognitive Limitations" which has been offered in many communities throughout the State and additional trainings will continue to be offered each year. To date, the Workgroup has trained close to 3,000 service providers through the work of an interdisciplinary, interagency training team. In addition to offering a conference for administrators and supervisors, and an international conference, the Workgroup also created an Interview Assessment Guide to assist workers in identifying these families. The

Workgroup has drafted recommendations regarding the use of plain language in communicating with all parents and developed a training on plain language.

The Department established an internal Workgroup to make recommendations regarding our practice with these families. Those recommendations are currently being reviewed through our Change Management system.

During the 2013 legislative session, the General Assembly passed Public Act 13-178, which directed the Department of Children and Families to produce a children's behavioral health plan for the state of Connecticut by October 2014. The Act required development of a comprehensive and integrated plan that meets the behavioral health needs of all children in the state and that prevents or reduces the long-term negative impact for children of mental, emotional, and behavioral health issues.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing mental health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system.

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR,

Inc., family advocates from the African Caribbean American Parents of Children with Disabilities, Inc. (AFCAMP), and consultants from Yale University took lead roles in input gathering activities, in partnership with CHDI staff.

A Steering Team and an Advisory Committee oversaw the process. The core elements of the input gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth
- Open Forums held in six locations and attended by 232 individuals
- Facilitated Discussions on 12 specific topic areas, attended by 220 individuals
- Website input forms submitted by over 60 individuals and groups

- After the draft Plan was posted to the website, 115 people submitted a total of 73 pages detailed comments and suggested changes.
- A review of background documents and data pertaining to the children's mental health system in Connecticut

The process yielded the identification of seven areas that will result in significant improvements to the children's mental health service system in Connecticut:

a. System Organization, Financing and Accountability

b. Health Promotion, Prevention, Early Identification, and Early Intervention

c. Access to a Comprehensive Continuum of Care

d. Pediatric Primary Care and Mental Health Care Integration

e. Disparities in Access to Culturally Appropriate Care

f. Family and Youth Engagement

g. Workforce Development

The Plan presents a set of goals and key strategies for each of these seven areas. This will continue to be an area of focus this upcoming year. Since the plans submission of the report on October 1, 2014, an Implementation Advisory Board has been developed. This group is comprised of other state agency representatives, parents, advocates, trade associations and private providers. A copy of the progress report detailing the activities that have occurred to implement the recommendations from this plan can be accessed via the following link.

Pursuant to Connecticut statute 17a-4, the Department convenes a Statewide Advisory Council (SAC). The SAC is to be comprised of 15 members, appointed by the Governor. The primary duties of the Council are to: review policies; recommend programs, legislation or other matters that will improve services for children, youth and families; review and advise the Commissioner on the proposed agency budget; perform public outreach to educate the community regarding policies, duties and programs of the Department and issue any reports it deems necessary to the Governor and the Commissioner

During CY 2014, the SAC met 8 times. DCF's Chief of Quality and Planning, a member of the

Commissioner's Executive Team, is staff to the SAC and attends every meeting. She has worked with the SAC to share information about Department initiatives, including those that specifically sought stakeholder feedback regarding service needs (e.g., Children's Behavioral Health Plan Forums). They have been provided a copy of the latest Child and Family Services Plan and APSR. The Department posts these documents plan on its website so that the SAC and other stakeholders can easily access it. They can be found via the following link.

The SAC also developed a "Presentation Agenda" for 2014. They identified specific priority areas in which they wanted presentation from various DCF divisions (e.g., Legislation, Education, Behavioral Health, Substance Abuse Services, Family Violence). The Chief of Quality and Planning has coordinated receipt of those requested presentations. In addition, a DCF update is a standing agenda item for every SAC meeting.

In addition, during the SAC's meeting year, the Commissioner's Executive team presents to them about the Department's goals, new initiative, and outcomes. Below is a listing of the Department's 2015+ 2016 Performance Expectations. The Chief of Quality and Planning went over these with the SAC. The Department's Office of Research and Evaluation has developed a Performance Expectations Report Card and it is posted on the DCF external facing website.

Next, in September 2014, the SAC convened a day-long conference to identify systems issues and possible solutions. Regional breakout sessions also occurred. The areas of challenge and next steps from that day are attached has guided a variety of discussions at subsequent SAC meetings.

In addition, each RAC has a representative on the SAC. The intention is that the SAC and RAC will connect to disseminate information locally and to bring ideas and issues up to a statewide level.

All RACs are provided with funds through the SAC to allow them to enhance stakeholder participation (especially parents/consumers) and to focus on areas of local priority. RACs are expected to submit an application to the SAC for these funds, outlining how they will be used. A report is also required by the SAC from each RAC to discuss how the funds were used and how the intended goals were achieved. RAC updates are a standing agenda item at every SAC meeting.

In addition to consulting with our advisory groups, the Department also receives considerable input from our service providers. The Department's senior leadership team meets quarterly with the provider trade associations and monthly with our credentialed providers to gather input of the effectiveness of our service array and quality improvement system.

Furthermore, twice a year, the Department convenes a statewide meeting for all its provider agencies to share the Department's progress toward our goals and to get input on further expansion of the service array. An invitation is extended to the SAC. The Department shares information about its service array, upcoming initiatives and relevant data. The attendees are given an opportunity to ask questions of the Commissioner and her leadership team. These meetings are televised on the public Connecticut Television Network (CTN) and the PowerPoint presentations are posted on the Department's website. Please see the screenshot of these postings. It is also a hyperlink that will take you to the actual webpage.

The last Statewide Provider Meeting was held in August 2015. This meeting featured a joint presentation by the DCF manager overseeing therapeutic foster care (TFC) and the manager of an agency that provides TFC services The meeting held in April 2015 had Regional breakout sessions. The focus of those breakout sessions was the identification of local needs. While a variety of different needs were identified, the Department was able to procure for the following services during 2015:

Work to Learn	This is a youth educational/vocational program providing supportive services to assist youth, ages 16-21, to successfully transition into adulthood. The program provides training and services in the following areas: employment skills, financial literacy, life skills, personal and community connections, physical and mental

	health, and housing. Youth also have the opportunity to take part in on site, youth run businesses.
Cognitive Behavioral Intervention for Trauma in Schools (CBITS) - RFQ	This is a skill based, group intervention aimed at relieving symptoms of Post-Traumatic Stress Disorder (PTSD) and general anxiety among children and youth who have experienced trauma. This school based treatment model will enhance the school's mental health service array to support student's learning potential and build resiliency.
Intimate Partner Violence - Family Assessment Intervention Response (IPV-FAIR) Repost	This service is to establish a comprehensive response to intimate partner violence that offers meaningful and sustainable help to families that is safe, respectful, culturally relevant and responsive to the unique strengths and concerns of the family. This service provides a supportive service array of assessments, interventions and linkages to services to address the needs of families impacted by intimate partner violence. The service will respond to both caregivers and the children. Safety planning will be at the center of the service provision.
Trauma-informed Therapeutic Child Care (TCC)	This is designed to promote, develop, and increase the social, emotional development and cognitive capacities of children, ages 2 years 9 months - 5 years who have been adversely affected by abuse and/or neglect, are presenting with behavioral health issues, and require a therapeutic and trauma-informed program to address these behavioral challenges. The program will be housed within a licensed childcare facility and will also offer support services to parents to increase positive behaviors and promote parent bonding. It is the goal of the Trauma-Informed Therapeutic Child Care Center that children will successfully transition to a less intensive educational setting as a result of the services offered.

Intensive Home Based Services: Multisystemic Therapy - Building Stronger Families (MST-BSF)	This service, using a national evidence-based treatment model, provides intensive family and community based treatment to families that are active cases with (DCF) due to the physical abuse and/or neglect of a child in the family and due to the abuse of or dependence upon marijuana and/or cocaine by at least one caregiver in the family. Core services include: clinical services, empowerment and family support services, medication management, crisis intervention, case management and aftercare. Average length of service is 6 - 8 months per family.
Intensive Home Based Services: Family-Based Recovery (FBR)	This service is an intensive, in-home clinical treatment program for families with infants or toddlers (birth to 36 months) who are at risk for abuse and/or neglect, poor developmental outcomes and removal from their home due to parental substance abuse. The overarching goal of the intervention is to promote stability, safety and permanence for these families. Treatment and support services are provided in a context that is family-focused, strength-based, trauma-informed, culturally competent, and responsive to the individual needs of each child and family. The clinical team provides intensive psychotherapy and substance abuse treatment for the parent(s) and attachment-based parent-child therapy to the parent-child dyad.

As a means to better address substance abuse service needs, the Department is launching a Social Impact Bond (SIB)/ Pay For Success project. Pay for Success (PFS) financing is a public-private partnership which funds effective social services through a performance-based contract. PFS projects enable federal, state, and local governments to partner with high-performing service providers by tapping private investments to expand effective programs.

In a PFS project, funders provide operating capital to strong service providers via a performance based contract; if, following a rigorous evaluation by an independent third party, the program achieves predetermined outcomes that benefit society and generate value for government, government repays the investment. If the project does not achieve its target results, government pays nothing.

The Connecticut Family Stability PFS project builds on the agency's efforts to promote child well-being and keep families together, by expanding proven services to families impacted by substance use, at risk of further involvement with the Department. The success of the project will be assessed by an increase family stability, and decrease in re-referrals to the Department. Through this PFS project, at risk families across Connecticut with children ages 0 - 6 are qualified to receive proven, intensive, in-home parent-child attachment support and substance use treatment.

Below are some other examples of how the Department has not only engaged the community to implement provisions in the CFSP, APSR, and a variety of other initiatives, but actions that DCF has taken to be responsive.

For example, input from myriad stakeholders in constructing Connecticut's Behavioral Health Plan for Children yield a variety of recommendations. Below are some of the enhancements that were made in response to that feedback:

Recommendation: Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children

Response: Effective March 2015, DCF executed a contract with Beacon Health Options (formerly Value Options) to establish Connecticut's first CME. Given this is the state's first effort the CME is focused on children and youth involved with DCF currently in congregate care and those at risk of needing a higher level of care. The CME, which provides services statewide, is designed to serve children and youth, ages 10-18, with serious behavioral or mental health needs who are returning from congregate care or other restrictive treatment settings (emergency departments/in-patient hospitals) or who are at risk of removal from home or their community. The CME provides direct services and administrative functions. At the direct service level, the CME employs Intensive Care Coordinators (ICCs) and Family Peer Specialists (FPS) who use an evidence based wraparound Child and Family Team process to develop a Plan of Care for each child and family. At the administrative level, the CME assists DCF in developing local and regional networks of care, which includes the CONNECT federal System of Care grant activities.

Recommendation: Many stakeholders noted significant increases in the number of youth presenting in behavioral health crisis to services such as Emergency Mobile Psychiatric Services (EMPS), EDs, and inpatient hospitals. Further expansion of this level of care is an immediate need and an important part of the overall system of care

Response: An EMPS expansion was effective January 1, 2016 and includes four adjustments:

- Staffing: Additional 2 FTE's per provider
- Hours of Operation: Increased hours of mobility from 8 am – 10 pm to 6 am – 10 pm
- Substance Use Screening: Utilize the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool and process to assess all adolescent youth for possible substance use problems.
- Suicide & Untimely Death Response: Enhanced support to the community and schools following an untimely death or death by suicide

In addition, DCF has been working closely with the EMPS Providers and the State Department of Education to fulfill the requirement in subsection (b) of section 17a-22bb that EMPS providers:

> *shall collaborate with community-based mental health care agencies, school-based health centers and the contracting authority for each local or regional board of education throughout the state, utilizing a variety of methods, including, but not limited to, memoranda of understanding, policy and protocols regarding referrals and outreach and*

liaison between the respective entities. These methods shall be designed to (1) improve coordination and communication in order to enable such entities to promptly identify and refer children with mental, emotional or behavioral health issues to the appropriate treatment program, and (2) plan for any appropriate follow-up with the child and family."

To date, 53 MOU's have been executed. The SDE is preparing a communication to Superintendents to highlight the importance of this requirement and the benefits of meaningful collaboration with EMPS providers in supporting students and families.

Recommendation: School-based behavioral health (Goal C.3). Many planning participants cited schools as ideal settings for screening, early identification of behavioral health needs, and delivery of and linkage to treatment services. Further expansion of school-based behavioral health care, in close cooperation with existing community-based clinics, is an important part of the overall system of care.

Response: In SFY 15, DCF contracted with four school based health centers in Bridgeport to implement Cognitive Behavioral Intervention for Trauma in Schools (CBITS) an evidenced based treatment model for children suffering from post-traumatic stress symptoms as a result of trauma experiences in their lives. The Department is in the process of expanding access through a Learning Collaborative to other schools across the state.

Finally, Connecticut currently has two federally recognized tribes: the Mashantucket-Pequot Tribal Nation (MPTN) and the Mohegan Tribe (MT). DCF maintains open communication with both tribes. Activity with the tribes is most often initiated after an accepted or non-accepted child maltreatment report to DCF's Careline.

For example, the Careline screens for MPTN involvement according to the case addresses (streets exclusive to the MPTN Reservation). If the case address is noted as a MPTN Reservation address, the report is non-accepted and the Careline takes the lead in notifying the Tribe of the report. The Tribe then chooses to investigate according to its own policies and procedures, with its own established CPS resources. The State is not involved in these circumstances. There are other circumstances in which the tribal member has an address off-reservation; in these cases the State does take action similar to non-tribal cases. The State provides immediate notice to the Tribe of the report.

Unlike the MPTN, the Mohegan Tribe (MT) does not have members living on a formal reservation/ tribal land. As such, all reports taken and accepted by the Careline are investigated (traditional Investigation or Family Assessment Response (FAR)) by the State and the MT is provided early notice. Virtually all CT Tribe (non-reservation) reports are serviced by the Norwich Area Office in DCF 's Region 3. Upon initial face to face contact, every accepted report of child abuse and neglect is screened for race and ethnicity demographics, capturing any ICWA information not initially indexed by Careline. Tribal affiliation is also screened and noted at this time. Results are stored in the State SACWIS system (LINK).

Most ICWA activity has centered on the State's resident tribes. On occasion there is activity regarding tribes in the neighboring states of Rhode Island, Massachusetts, and New York. Also notable is the practice of both casinos to exercise Native American hiring preference in their gaming and hospitality enterprise; this has resulted in many (and all required) ICWA notices to be filed with Tribes across the nation and BIA.

There is a longstanding Memorandum of Understanding between the State and the MT. There is no similar agreement with the MPTN. There are ad hoc meetings scheduled with the MT. The content of the meetings is oriented to the Memorandum of Understanding. This includes case specific discussion of State interventions with MT members. The State notifies the MT of all accepted reports regarding their members. Discussion is held in a confidential meeting at Tribal Offices. The meetings are also used as an opportunity to advise the Tribe of new State initiatives; recent past and present discussions have included Structured Decision Making, Differential Response System and Considered Child and Family Team Meetings for Considered Removals.

Regarding the MPTN, while no formal arrangement is in place for regular meetings, there is a well noted single point of contact, their Director of Child Protection. The State continues to have a positive working relationship with the Director.

As noted above, DCF screens for ICWA compliance with demographic Inventories /interviews at the point of all DRS activity. There are additional checkpoints that also capture/create safeguards for identification/notifications. These include genograms completed with families (at investigation or FAR) and revised by ongoing DCF social workers in the formulation and revision of case plans; internal multidisciplinary assessments for permanency (MAPS) in which DCF legal and Social Work staff discuss cases in which legal intervention has transpired; as well as canvassing of all parties once court involved.

Consistent with ICWA, all tribes are notified of State legal activity in writing, by USPS certified mail. For the States' two local tribes, by working convention and courtesy, telephone notice precedes written notification. Common Juvenile Court practice finds representatives of the two local tribes present, at least for initial proceedings. Neither Tribe has a formally developed system of resources (foster/host homes/group care) that allows for a diversionary path from State care, should removal from home become necessary. In 2013, DCF adopted the practice of Considered Removal Child and Family Team Meetings and in 2014, Child and Family Permanency Teaming was implemented. For Tribal families, there is explicit instruction given by DCF that the family is welcome to invite Tribal resources to these meeting forums.

Jurisdiction with the proceedings occurs with exclusivity to the State juvenile court system. The MT does not seek to transfer cases to its own court network and prefers to partner with the State in the Superior Court for Juvenile Matters. Conversely, the MPTN often exercises the option of jurisdiction moving to its court network.

There have been no ICWA compliance issues identified with the MPTN or MT over the last six years. Some DCF Area Offices have undertaken recent training efforts on ICWA. Newly hired Social Workers are trained on ICWA during pre-service training. Participation in a monthly, country-wide telephone conference also occurs with either the Norwich Area Office Principal Attorney and/or Program Manager for Intake. This has served to keep the office/agency abreast in any changes to ICWA as well as create awareness for training opportunities.

Other activity with the tribes included a 2015 invite for participation in the development of a Substance Exposed Infant (SEI) and the Fetal Alcohol Spectrum Disorder (FASD) prevention and identification initiative. There has not been any recent negotiations with the MT or MPTN specifically as it relates to

determining eligibility, benefits and services and ensuring fair and equitable treatment for Indian youth under the Chafee Foster Care Independence Program (CFCIP).

In sum, during the development of the Department's strategic plan, the SAC, CBHAC, RACs and other stakeholder groups were consulted for their input and feedback. The input of stakeholders helped inform the Department's assessment of its performance and identify goals and objectives for the plan. The strategic plan goals and objectives that were developed with collaboration from our stakeholders have been integrated into the 2015-2019 CFSP. The development of the CFSP, included consultation and feedback from various community stakeholder groups about how the Title IV-B services in the plan can best be aligned to meet our goals and objectives for the five year period. We will continue to consult with our advisory councils, the courts and other stakeholders during the five-year implementation of the CFSP. This occurs through standing agenda item updates from the Department, regular presentations from DCF leaders, and an annual SAC/RAC retreat attended by the Commissioner, her Team and the DCF Regional and Central Office Administers.

Item 32: Coordination of CFSP Services With Other Federal Programs

How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population?

Please provide relevant quantitative/qualitative data or information that show the state's services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population.

State Response:

The CT Behavioral Health Partnership (BHP) is a legislatively mandated collaboration between the Department of DCF, the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS) and is designed to create an integrated behavioral health service system for Connecticut's Medicaid populations, including children and families who are enrolled in HUSKY Health and DCF Limited Benefit programs. The State Agencies have contracted with Value Options, Inc. to serve as the Partnership's Administrative Services Organization which provides utilization management, clinical oversight and quality assurance activities related to all Medicaid funded behavioral health services and selected DCF grant funded services.

The Partnership's goal is to provide access to a more complete, coordinated, and effective system of community based behavioral health services and support. This goal is achieved by making enhancements to the current system of care in order to:

- *Provide access to a more complete, coordinated and effective system of community-based behavioral health services and supports*
- *Support recovery and access to community services, ensuring the delivery of quality services to prevent unnecessary care in the most restrictive settings*
- *Enhance communication and collaboration within the behavioral health delivery system and with the medical community, thereby improving coordination of care*
- *Improve network access and quality*
- *Recruit and retain traditional and non-traditional providers*

In CY 2014, over 53,000 Medicaid enrolled children and youth (under age 18) utilized a behavioral health service and approximately 5000 of these individual children were involved with DCF through child welfare, juvenile justice or voluntary services. Program targets for the CT BHP have been on identifying youth with frequent and unnecessary behavioral health visits to the emergency department in order to propose crisis planning and diversionary interventions, and monitoring youth with repeat inpatient admissions. The Partnership also continues to focus on strengthening the provider network for IICAPS, an intensive home-based intervention designed to help youth with psychiatric challenges who have had previous inpatient stays to succeed at home and in the community.

The Department also works closely with the CT Department of Developmental Services. DDS works with individuals who have developmental disabilities and are likely to need support and services throughout their lifetime. DDS has an array of services and has been able to target resources, which are not available to the general public, specifically to youth aging out of DCF.

Special transition initiatives between DCF and DDS are occurring. This supports the coordinated transfer of the following populations:

a) DCF Voluntary cases to the DDS Voluntary Program;

b) Children on the autism spectrum to the DDS Autism Division Medicaid

Waiver program; and

c) Early age outs to DDS prior to age 21

As of May 2015, DCF has identified 201 children/adolescents who have been referred to and made eligible for DDS and who will eventually transition to adult services, typically at age 21. DCF and DDS maintain a "shared client list" which is updated regularly to assure that DCF involved youth are identified, referred and transitioned. DCF has been tracking transitions to DDS since SFY 2011, and an average of 73 youth per year have transitioned to DDS.

DDS also has a program for children and adults on the autism spectrum (ASD) but who do not have intellectual disabilities. The program has a limited number of slots and only 50 for children. In FY 13 and 14, DCF transitioned 36 youth to this program. In addition, DCF maintains a list of eligible youth for transition when space is available. The waiting list for these services is anticipated to be reduced over time with the implementation of the state's Medicaid coverage for children with ASD up to age 21, which give some families another option for services.

See also Items 25, 29 and 31 for additional examples of how the Department collaborates and coordinates with other systems and partners.

G. Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: Standards Applied Equally

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that state standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

> Please provide relevant quantitative/qualitative data or information that show the state's standards are applied equally to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds.

State Response:

All significant aspects of the Department's licensing, recruitment and retention systems are standardized across the State and applied equally. As the Department has six (6) Regions, there are elements of these systems that allow for Region specific implementation. Other systems have some element of discretion around whether they will be utilized. For example, all Regions have the ability to pursue certain waivers for regulatory requirements. What one Region might decide to pursue, another would not. Once utilized the established protocol must be followed. It should be noted, however, that only select waivers may be approved by the area offices. Waivers that involved a criminal history and/or a CPS history are required to be approved by the Commissioner. During the last quarter of Calendar Year 2015, the Commissioner received 13 waivers and approved all of them. From January 2016 – March 15, 2016, the Commissioner received 11 waivers but only approved 8 of them. The other three while not approved are being discussed with the Regions to determine if there is additional information or other activities that should occur to better determine if such waivers might ultimately be approved. The Commissioner does expect that the Regional Administrator review and vet the waiver request before they are submitted to her.

The Department contracts with private providers for the provision of Therapeutic Foster Care services. These contract include funds to support at least a .5 FTE recruiter for each agency. They too are expected to create annual R&R plans. In addition to general recruitment, TFC provides are expected to engage in child specific recruitment as may be required to support an effective match. This is detailed in their contract. Additional funds have been added to the TFC contracts to better support these efforts.

All licenses are renewed on a bi-annual basis. The foundation of the system to ensure that no license lapses is manual. The Department's SACWIS system, LINK, generates a report that is used as an added management tool. This is generally a coding issue whereby LINK may pull in homes that are actually deactivated but were not properly noted as such by a social worker. The logs maintained by the FASU staff are more accurately representative of the true number of open and active homes. These data are used as a starting point, as the current capturing process in LINK may not be fully representative of the correct universe. These data, however, are detailed to allow for analysis at the Statewide, Region and Area Office levels. Data as of December 7, 2015 indicates of the 2838 total licensed homes, including those for adoptive care, approximately 1% have a lapsed license. Of the homes identified to have a lapsed license, kinship homes represent about 34% of the number. A lapsed license is one that is due for renewal; there has been an existing license and the two year renewal period has been reached.

Data further suggests that there are 165 homes with a placement that have an overdue license. An overdue license occurs in a situation where a child has been placed in the home, but the initial license has not yet been generated. The data detail indicates that 100% of those homes are kin (relative/special study) placements. This is significant context. Given the importance of placing children with relatives, it is generally not in the best interest of the child to seek to change placement in instances when there has not been timely receipt or timely follow-up with respect to efforts to finalize or renew a license.

Row Labels	Count of Service Type
Age 0-5 Special Study Foster Care	14
Age 12-17 Special Study Foster Care	12
Age 6-11 Special Study Foster Care	7
Relative Care,Age 0-5	83
Relative Care,Age 12-17	16
Relative Care,Age 6-11	33
Grand Total	**165**

As a means to support timely license renewals, DCF Foster Care and Adoption Support Unit (FASU) social worker prints out a listing of each of the licensed families that they support. This listing reflects the dates that their license expires. Prior to the expiration of the license, families who wish to maintain licensure sign a renewal application. Pursuant to guidance from our Legal Division, the existing license remains in effect once the application is signed until further action on the license (renewal or closing) is taken.

Next, all existing licensed families were audited by FASU staff for a period of time in 2011. This continuous review occurred until all homes were audited to ensure that their records contained all required documentation for licensure. The current practice is that each family is reviewed by a Supervisor at the time of licensure to ensure that all required elements are completed and that all required documentation has been secured and is part of the record. There is another review at each additional renewal (every two years). The file is also checked at time of closing to ensure everything is uploaded into LINK (criminal/CPS background check documents). Thus, 100% of our licensed homes are reviewed every two years congruent with their renewal cycle.

With respect to training and licensing, basic standards are consistent. Every Region utilizes the TIPS-MAPP training curriculum and the same Home Study Assessment format. Each Region utilizes the same process for review by both a Social Worker and their Supervisor. The Regions use a standardized checklist to ensure each licensing element has been completed. This checklist is filled out by the social worker and then reviewed by the Supervisor. In some instances, when certain items are observed (e.g., trauma history, criminal or CPS history) there is also a review by the Manager.

There is also a standardized process for approving acceptable waivers to the licensing requirements. A template has been created which outlines the areas that require waiving and who is authorized to invoke a given condition's waiver. It still remains the discretion of the Region to decide if they want to pursue a waiver or not. This means that Region may not choose to pursue a waiver for a variety of reasons (e.g., risk tolerance) and may instead move forward with another placement option. This does not mean that the Regions can disregard a condition requiring a waiver and place absent the granting of such waiver. Thus some Regions are more apt to seek a waiver versus another. As has been noted, any waivers that involve a criminal or CPS history must be reviewed and approved by the Commissioner before a placement may occur.

Finally, a foster care canned reports suite is available to DCF staff. These reports can be drilled down to dataset at the child, foster parent and/or provider agency level. These available report and data further support standard review, monitoring and oversight of Connecticut's foster care system. A screenshot of these reports is below:

OFAS	
Active Providers With Lapsed Licenses	Foster care and Pre-adoptive providers with current foster/pre-adoptive care placements.
Bed Cap Report	Provider Bed capacity at month-end
Child Age Daily Report	Daily Age Of Children In Placement
Child Age Report	Age of Children In Placement at End-of-month
Child Placed Daily Report	Count of Children placed daily
Child Placed Report	Month-end count of children placed
CIP Provider Addresses	Addresses of Providers for all children in placement.
Foster Care Inquiries	Foster Care Inquiries for the prior month
Foster Care Investigation Dispositions	Investigations of CPS Reports of the type DCF Licensed Provider and Other Provider.
Foster Home Race Ethnicity Report	Race and ethnicity for foster home parents
Home Visit	Detail records for the past two years for providers home visits
Home Visit Last	Summary data by office for last provider home visit within the last two years
Licensed Providers and Providers With Parent Agencies	All DCF Licensed providers, by Area Office, License Type and License Status. Licensed Providers Attached to Parent Agencies
Mental Health Block Grant	Unduplicated counts of children served for specific service types supplied by requestor.
Overdue Licenses	Children in placement with a Relative Care or Foster Care Provider who does not have a valid license. Report excludes children 18 and over.
Phone Call	Detail records for the last two years of provider phone call contacts
Phone Call Last	Summary by office of last phone call contact with provider within last two years
Placements Out Of Stat Compliance	Children In a Placement Out of Statutory Compliance.
Private Agency Foster Care CIP	Children In Placement with a provider who is connected to a parent provider agency.
Providers On Hold Due To Investigation	Providers on hold due to an open investigation.
Providers with licenses expiring within 90 days	Providers with licenses that expire within 90 days.
SafeHome, PDC, and Shelter Time In Placement	Time in Placement for all children in Safe Home and PDC placements.

tem 34: Requirements for Criminal Background Checks

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

> Please provide relevant quantitative/qualitative data or information that show the state is complying with federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children.

State Response:

As noted earlier, each of the Regions conducted audits/reviews of all existing licensed families following recommendations generated during an earlier CFSR review. New systems went into effect to clarify and ensure that all required background checks had been completed and that the requisite documents were part of the foster parent's record. Various combinations of the FASU Social Worker, Supervisor and Program Manager check for all required documents at initial licensing, relicensing and again at closing. Please also see Item 33 for discussion of the Department's licensing review and audit process, and the success of its functioning

The FASU staff have an important partnership with Revenue Enhancement Division (RED) as well. RED checks the electronic record of each licensed foster parent to ensure that all requisite licensing documents are secured, which makes foster children in that home IV-E eligible. When a child enters care and when a license closes, RED receives notification and they check to make sure requisite documents are in the Department's electronic document storage system, eDocs. Starting in January 2012, RED began notifying local FASU and CO staff with a weekly list of the homes where they have identified missing documentation. As of December 23, 2015, RED had requested documents on 234 foster care providers for CY 2015.

Using these lists, FASU then searches for the document and if they cannot locate it they ensure that the background check gets done immediately. This system serves two purposes – 1) to make sure that the home is properly licensed and that is supported by proper documentation and 2) that the Department doesn't submit IV-E claims where criteria hasn't been met.

Private agency foster care families were similarly audited over the past few years and systems were established for the Department to review all required documents prior to issuing a license. RED reviews these families as well.

At the beginning of the month RED also reviews the placements that comprise initial determinations and redeterminations. For December 2015, RED has been assigned 359 that fit these two categories for kids between 0 -18. RED is also assigned on a weekly basis interim determinations, one of which is for expired licenses. In November, RED was assigned 171 interim determinations. 67 of the 171 interim determinations were for expired licenses. The last quarterly list that went out for the still outstanding

licensing issues was in early October and there were 68 providers on the list. The list for November had only 11. So far for December, there are 25.

The Department recently implemented a major change in its background check process by streamlining the involvement of our partner agency, the Department of Emergency Services and Public Protection. We no longer require them to generate a Background Investigation Unit packet for us. They only generate Federal and State fingerprint results. DCF is able to generate all other required background checks. An area of focus is to shorten the time it takes to process background checks which will result in ensuring licenses are generated in a timely manner. At the time that this change went into effect it would often take 3-5 months to get the packet from the BIU. It is our hope that we will achieve a reduction in time to complete by 75% so that background checks are completed within 35 days. The new system went into effect in October 2015 and data is not yet available.

If a background check reveals a history there is first an assessment of whether that particular incident violates any regulatory or statutory requirements. If no, then there is discretion to proceed with the licensure and to secure additional reports available about the incident and to discuss with the party. If it is a precluding incident then the Department must assess whether the matter is waivable. If it is, then they must further assess the situation, render a justification for pursuing licensure and seek approval from the Commissioner.

Last, trained foster care support staff visit the Foster home at a minimum on a quarterly basis and have monthly phone contact with al foster parents with DCF-involved children in their home. Any concern around safety is pursued via a system called Assessment of Regulatory Compliance (ARC). If safety concerns are identified a range of responses could occur dependent upon the level of risk identified - from corrective action to removal of the child from the home. An ARC is employed when it is termed that there is a violation of regulatory compliance at the foster home level. This could include a licensing issue such as a background check. For example, it may be determined that a person over age 16 (no foster child) has moved into the home and has not received the requisite background checks, including fingerprinting.

In 2015, there were 262 reports[15] on licensed approximately 1097[16] Therapeutic Foster Homes, including TFC respite homes. This represents 147 of these reports were not accepted for investigation by the Department Of the 115 that were accepted for investigation, 34 of those were identified to have Regulatory Concerns requiring an ARC. It should be noted that the Department has a group termed the Special Investigations Unit (SIU) that engages in investigations that involve foster parents, provider agencies and/or DCF employees. The SIU is part of the Department's centralized intake called, Careline. The SIU Manager reports directly to the Careline Director.

The below are some CY 2015 data regarding TFC and DCF Core/Relative foster homes that were closed or are facing possible closure for cause:

---

[15] It should be noted that any given home could have more than 1 report.

[16] This is an approximated CY 2015 unduplicated count of the number of TFC and TFC Respite homes. This is an approximation as some respite homes transfer over from being TFC. The per month count of those respite homes range in number from about 114 – 132.

TFC:

- 3 closures as a result of a Substantiation
- 4 closure with no Substantiation, but with regulatory concerns
- 1 going through waiver process
- 2 going through appeals

CORE/Relative:

- 20 homes were closed because they no longer met DCF licensing requirements
- 4 homes were closed following an investigation
- 4 homes had their license revoked

Item 35: Diligent Recruitment of Foster and Adoptive Homes

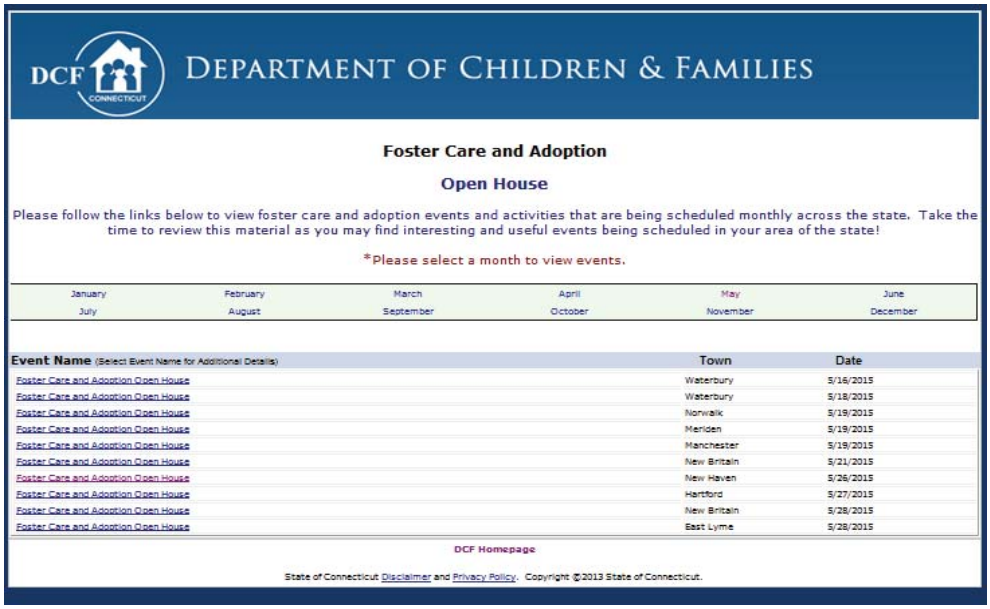
How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

> Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide.

State Response:

Department engages in both generic and targeted recruitment activities. The general activities are aimed at attracting any person that might be interested in foster care – this includes billboards, distribution of materials at large events, and online via a website, Facebook and other technology. Child specific recruitment occurs in a myriad of ways, including searching for families for specific cohorts of children (teenagers, siblings, African American or those with complex medical needs) or for a specific child. The screenshot on the side presents the recruitment expectations for Therapeutic Foster Care.

The DCF website also includes a "calendar" of foster and adoptive family open house events to support recruitment.



DCF CONNECTICUT DEPARTMENT OF CHILDREN & FAMILIES

Foster Care and Adoption

Open House

Please follow the links below to view foster care and adoption events and activities that are being scheduled monthly across the state. Take the time to review this material as you may find interesting and useful events being scheduled in your area of the state!

*Please select a month to view events.

January	February	March	April	May	June
July	August	September	October	November	December

Event Name (Select Event Name for Additional Details)	Town	Date
Foster Care and Adoption Open House	Waterbury	5/16/2015
Foster Care and Adoption Open House	Waterbury	5/18/2015
Foster Care and Adoption Open House	Norwalk	5/19/2015
Foster Care and Adoption Open House	Meriden	5/19/2015
Foster Care and Adoption Open House	Manchester	5/19/2015
Foster Care and Adoption Open House	New Britain	5/21/2015
Foster Care and Adoption Open House	New Haven	5/26/2015
Foster Care and Adoption Open House	Hartford	5/27/2015
Foster Care and Adoption Open House	New Britain	5/28/2015
Foster Care and Adoption Open House	East Lyme	5/28/2015

DCF Homepage

State of Connecticut Disclaimer and Privacy Policy. Copyright ©2013 State of Connecticut.

Next, every Region generates a Recruitment and Retention (R&R) plan on an annual basis. The Regions look at the requests for matches they received the previous year and make decisions based on that information (i.e., many requests for adolescents and sibling groups that they had difficulty making). Regions also look at the overall Children In Placement data for their Region (i.e., 60% of children in care are teenagers). As they review the CIP data, they also look at race and ethnicity, age and gender. While

there are statewide trends reflected in these plans, they are individualized by Region based on identified needs. R&R plans differ in content dependent upon the needs of Region, but a consistent format is used now that is based on Results-Based Accountability concepts. The plan guides the Regions to focus their efforts around the outcomes they need to achieve. A sample regional Recruitment and Retention Plan is included as an Appendix.

Retention activities are not standardized, as they are specific to the Regions' populations and identified needs. Each Region has its own funds for retention and they expend them as they deem appropriate to meet the needs of their families. FASU staff do share information about their activities so that Regions can both collaborate on events and replicate them. There are times when all of the Regions will collaborate on a statewide event. (e.g., Statewide Kinship Conference for licensed kinship caregivers.)

The most significant concerted recruitment effort that DCF has engaged in in the past few years is to increase the number of relative placements. In just four (4) years the number of children placed with kin increased from 21% in 2011 to just over 40% currently and over 40% of children who enter care for the first time are now placed with relatives.

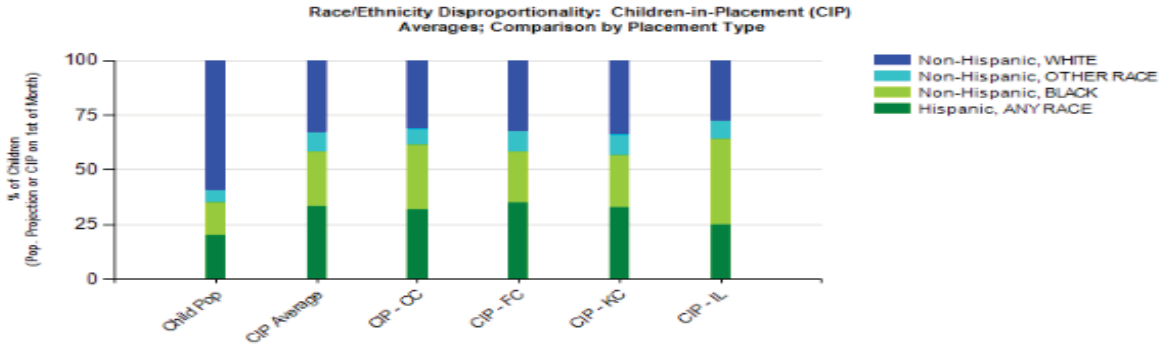
As noted earlier, every Region generates a Recruitment & Retention plan on an annual basis. The Regions look at the requests for matches they received the previous year and make decisions based on that information (i.e., many requests for adolescents and sibling groups that they had difficulty making). Regions also look at the overall Children In Placement (CIP) data for their Region (i.e., 60% of children in care are teenagers). As they review the CIP data they also look at race and ethnicity, age and gender. While there are statewide trends reflected in these plans, they are individualized by Region based on identified needs. R&R plans differ in content dependent upon the needs of Region, but a consistent format is used now that is based on Results-Based Accountability concepts. The plan guides the Regions to focus their efforts around the outcomes they need to achieve.

Annualized Children in Placement data, crosstabulated by race and ethnicity, by Region and Area Office are below:

REGION	OFFICE	HISPANIC	BLACK	OTHER	WHITE	TOTAL
1	Bridgeport Office	250	204	32	79	565
1	Norwalk/Stamford Office	78	57	10	54	199
1 Total		328	261	42	133	764
2	Milford Office	99	75	60	270	504
2	New Haven Office	141	236	19	45	441
2 Total		240	311	79	315	945
3	Middletown Office	25	16	21	112	174
3	Norwich Office	116	67	97	317	597
3	Willimantic Office	73	13	18	218	322
3 Total		214	96	136	647	1093

4	Hartford Office	275	214	49	52	590
4	Manchester Office	92	66	56	194	408
4 Total		367	280	105	246	998
5	Danbury Office	107	18	32	167	324
5	Torrington Office	30	3	19	132	184
5	Waterbury Office	237	103	67	226	633
5 Total		374	124	118	525	1141
6	Meriden Office	97	21	21	81	220
6	New Britain Office	165	55	53	258	531
6 Total		262	76	74	339	751
Grand Total		1785	1148	554	2205	5692

The below graphic shows child race and ethnicity data more discretely by congregate, foster care and relative/kin placement. This is important information to better examine equity in family and relative placements.



	Hispanic, ANY RACE		Non-Hispanic, BLACK		Non-Hispanic, OTHER RACE		Non-Hispanic, WHITE		Grand Total	
Month / Year	#	%	#	%	#	%	#	%	#	%
Child Pop	154,258	19.9%	114,422	14.8%	46,298	6.0%	458,582	59.3%	773,559	100%
CIP Average	1,321	33.1%	1,003	25.1%	360	9.0%	1,310	32.8%	3,994	100%
CIP - CC	182	31.4%	173	29.9%	42	7.3%	182	31.4%	579	100%
CIP - FC	605	34.8%	405	23.3%	161	9.3%	568	32.7%	1,739	100%
CIP - KC	486	32.7%	350	23.6%	142	9.6%	507	34.1%	1,485	100%
CIP - IL	47	24.7%	74	38.9%	16	8.4%	53	27.9%	190	100%

Averages are based on CIP on the 1st of the month from:
Starting Month: December - 14 Ending Month: December - 15

Legend: CIP - Children-in-Placement, CC - Congregate Care, FC - Foster Care, KC - Kinship (Relative or Special Study) Care, IL - Independent Living

Next, the Department has a contract with the Connecticut Association of Foster and Adoptive Parents (CAFAP) to develop and carry out retention activities intended to improve foster and adoptive parent satisfaction in their role, leading to more foster and adoptive parents continuing their partnership with DCF. They have a dedicated Retention Specialist position that works to "retain" families who have expressed interest in becoming foster/adoptive parents and those are currently licensed. The below data from the CAFAP report for the period of October 1, 2014- December 31, 2014. A copy of the January 2016 CAFAP quarterly Report has been included as an Appendix.

Post-Licensing Retention

- CAFAP Retention Specialist attempted to contact 82 families who were approaching renewal of their license for the first time. 25 families responded.
- 21 families indicated their intention to renew their license. All reported positive relationship with DCF.
- 3 families indicated their intention to close their license. Of those who reported their intention to close, the reasons provided were:
  - 3 Adoption or Transfer of Guardianship. or Adoption planned
- 1 family indicated they were unsure of their intentions.

CAFAP also participates in DCF initiated foster/adoptive parent retention activities including, but not limited to, providing staffing for special events and raising awareness of events. Further, they assist the Department with ensuring foster and adoptive parent representation on various committees that impact foster/adoptive care practice.

Finally, CAFAP targets retention efforts at licensed foster and adoptive families who are in their first term of licensure and approaching their renewal date. This targeted retention includes myriad outreach efforts including, but not limited to telephone calls, e-mail and home visits. CAFAP is expected to analyze their quantitative and qualitative data to make recommendations to DCF so as to improve retention.

The below table sets forth home licensing and closure information by Region for the 3rd Quarter of CY 2015:

3rd Qtr (July-Sept) 2015 STATUS REPORT

	LICENSED HOME DATA	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
1	Number of Foster Homes Licensed During 3rd Quarter	4	7	9	1	4	10
2	Number of Foster Homes Closed During 3rd Quarter	6	14	7	3	7	10
3	Total Number of licensed Foster Homes as of Sept 2015.	107	76	151	175	167	127
	ADOPTION DATA						
1	Number of Adoptive Homes Licensed During 3rd Quarter	3	13	3	0	4	2
2	Number of Adoptive Homes Closed During 3rd Quarter	2	4	2	6	5	2
3	Total Number of licensed Adoptive Homes as of Sept 2015.	27	32	56	45	54	21
	FICTIVE KIN DATA						
1	Number of Fictive Kin Homes Licensed During 3rd Quarter	2	3	8	2	6	5
2	Number of Fictive Kin Homes Closed During 3rd Quarter	2	6	6	6	6	9
3	Total Number of Licensed Fictive Kin as of Sept 2015.	20	22	47	42	36	22
	INDEPENDENT DATA						
1	Number of Independent Licensed During 3rd Quarter	1	2	1	0	6	1
2	Number of Independent Closed During 3rd Quarter	0	0	2	3	5	1
3	Total Number of licensed independents as of Sept 2015.	8	3	14	12	36	9
	KINSHIP DATA						
1	Number of Kinship Homes Licensed During 3rd Quarter	14	12	24	13	19	18
2	Number of Kinship Homes Closed During 3rd Quarter	13	13	23	9	26	23
3	Total Number of licensed Kinship Homes as of Sept 1, 2015.	56	62	146	140	120	83
4	Total Numbers of licensed Kinship Homes as of Sept 2015.	60	67	140	139	123	75
	Total Number of New Homes Licensed	**24**	**37**	**45**	**16**	**39**	**36**
	Total Number of Closed Homes	**23**	**37**	**40**	**27**	**49**	**45**

Finally, over 58% of the children in placement with DCF are Black and Hispanic. Currently, about 40% of children in placement are living with kin. 56% of these placements are of children and color. Demographic data with respect to our current foster homes (based upon the race/ethnicity of "Parent 1) is presented below:

Race Foster Parent 1	Count
American Indian Or Alaskan Native	1
Asian	8
Black/African American	302
Hispanic	141
Unable To Determine	41
Unknown	23
White	981
Grand Total	**1497**

There are 129 homes where Parent 2 identifies as Hispanic. There are 319 homes where Parent 2 is identifed as Black/American American.

The Department has made tremendous strides in better ensuring that children are placed with relatives (increased from 21% in 2011 to 40% as of December 2015). This work has inherently supported better ensuring that foster homes are representative of the children to be served. Enhanced analysis of core foster home data must occur to ensure that a cadre of diverse homes are readily available for placements.

Other aspects of improved work include better collaborations between DCF and the Child Placing Agencies, as well as better communication across Regions to share resources to ensure that children are matched with most appropriate available home every time.

Item 36: State Use of Cross-Jurisdictional Resources for Permanent Placements

How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

Please provide relevant quantitative/qualitative data or information that show the state's process for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children is occurring statewide.

Please include quantitative data that specify what percentage of all home studies received from another state to facilitate a permanent foster or adoptive care placement is completed within 60 days.

State Response:

The Department has a very active Interstate Compact Office. In Q1 of State Fiscal Year 2016 (July – September) the ICO processed 219 requests. (This includes for children going out of CT as well as children coming into CT.) For the calendar year of 2015, the ICO received 741 requests from other States.

There are currently 88 CT children placed across State lines. The average amount of time it took from submission of referral to time of placement on average was 2.4 months. For children coming into CT, we have a process that includes both the ICO and the Regions, which do the actual home assessment. Preliminary data analysis shows that the timeframe for completion of those assessments takes on average 90 days. The ICO does follow up with the Region to remind them of critical deadlines.

The Department will begin using National Electronic Interstate Compact Enterprise (NEICE), a web-based electronic case-processing, starting in July 2016. NEICE supports the exchange of ICPC data and documents across states. The Department thinks that NEICE will speed-up the placement process for children and also support 45% workload and significant cost savings (electronic v. $25 average mailing of documents) for CT. The below chart presents the process time improvements expected by utilizing NEICE:

CURRENT VS NEICE PROCESS

TIME FRAME COMPARISON BETWEEN NEICE AND NON-NEICE CASE PROCESS

From NEICE Evaluation Report	Non-NEICE Process		NEICE Process	Time Savings %
Priority Reg. 7 Request (Relative Unlicensed)	• Average of 11 days to initiate Priority requests and send it to Receiving State	VS	6 Days	45%
	• Average of 44 days to conduct Priority Study and issue placement decision	VS	16 Days	48%
Foster Home Study Request (Licensed)	• Average of 24 days to initiate Foster Home Study Request and sent it to Receiving State	VS	13 Days	46%
	• Average of 57 days to conduct Foster Home Study and issue a placement decision	VS	42 Days	26%

At the end of September 2015, there were 62 licensed Independent foster homes, those that are licensed for a specific child coming from outside the State of Connecticut. During Quarter 1 of SFY 2016, there were 11 new Independent homes licensed.

The Department rarely complies with the requirement to generate a placement approval within 60 days due to our requirement that a home be fully licensed prior to issuing such an approval. Most states generate a relative approval that does not include full licensure (training, return of finger print results). As noted above, on average it takes approximately 90 days to license, but it ranges from 3-6 months.

The Department does generate an Assessment for Child Specific Interstate Compact Request Prior to Licensing (Form 008-IC). This entails preliminary background checks, a walkthrough of the premises and preliminary personal interview with the prospective caregiver. This is provided to the sending state to assess if they wish to move forward with full licensure. Unless it is a relative, Connecticut does not permit placement of a child into a home unless the home is fully licensed. This applies to youth coming to us from other States as well.

The Department also utilizes national resources to further permanency work. This includes an ongoing relationship with AdoptUsKids as well as a growing and extremely successful partnership with Wendy's Wonderful Kids. Recently, the Department committed funding through a contract to increase the staffing at the State's WWK provider. WWK has been instrumental in supporting the Department's permanency work with youth who have been identified as harder to place.

Areas for Improvement: The Department needs to implement strategies to achieve compliance with placement of children in a safe and timely manner (60 days) upon request.

Connecticut Statewide Self-Assessment

APPENDIX

Blank Administrative Case Review Instrument
Sample Operational Strategies
DCF AFCARS SACWIS System Changes
Sample RBA Report Card (see website link)
Sample Service Array and Resource Assessment (SARA) Meeting Minutes
DCF Contracted Services Listing (funding level, capacity and geography served)
CAFAP Quarterly Report
Sample Regional Recruitment and Retention Plan

i