Juan F. v. Rell Exit Plan
Quarterly Report
July 1, 2006 – September 30, 2006

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Juan F. v Rell Exit Plan Quarterly Report
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Highlights

1. The Monitor's quarterly review of the Department of Children and Families (DCF) efforts toward meeting the Exit Plan measures during the period July through September 2006 indicates that the Department sustained most of its previous achievements and has for the first time met Discharge of Children to the Department of Mental Health and Addiction Services and the Department of Mental Retardation (Outcome Measure 21). Outcome Measure 21 is a 100% compliance measure that requires the Department to submit written discharge plans prior to the child's discharge from DCF's care to either DMHAS or DMR for all children that require adult services.

2. The Monitor's quarterly report review of DCF for the period of July through September 2006 indicates that DCF has achieved compliance with a total of 17 measures.
    - Commencement of Investigations (98.7%)
    - Completion of Investigations (94.2%)
    - Search for Relatives (93.1%)
    - Maltreatment of Children in Out-of-Home Care (0.8%)
    - Reunification (62.5%)
    - Timely Transfer of Guardianship (70.2%)
    - Re-entry into Care (4.3%)
    - Multiple Placements (95.6%)
    - Foster Parent Training (100%)
    - Placement within License Capacity (96.7%)
    - Worker to Child Visitation in Out-of-Home Cases (92.5%)
    - Worker to Child Visitation in In-Home Cases (85.7%)
    - Caseload Standards (100%)
    - Reduction in Residential Care (10.9%)
    - Discharge Measures (100%)
    - Discharge of Mentally Ill and Mentally Retarded Children (100%)
    - Multi-disciplinary Exams (86%)

3. DCF has maintained compliance for at least two (2) consecutive quarters[1] with 12 of the Outcome Measures shown above (number of consecutive quarters indicated below):
    - Commencement of Investigations (eighth consecutive quarter)
    - Completion of Investigations (eighth consecutive quarter)
    - Search for Relatives (fourth consecutive quarter)
    - Maltreatment of Children in Out-of-Home Care (eleventh consecutive quarter)
    - Reunification (fifth consecutive quarter)
    - Multiple Placements (tenth consecutive quarter)
    - Foster Parent Training (tenth consecutive quarter)
    - Worker to Child Visitation in Out-of-Home Care (fourth consecutive quarter)
    - Worker to Child Visitation in In-Home Care (fourth consecutive quarter)
    - Caseloads Standards (tenth consecutive quarter)
    - Residential Reduction (second consecutive quarter)
    - Multi-Disciplinary Exams (third consecutive quarter)

4. The Monitor's quarterly review of DCF for the period of July through September 2006 indicates that DCF did not achieve compliance with five (5) of the measures:
    - Treatment Plans (54%)
    - Repeat Maltreatment (7.9%)
    - Adoption (27%)
    - Sibling Placement (83%)
    - Needs Met (62%)

5. The Monitor implemented a revised methodology to measure Needs Met (Outcome Measure 3) and Treatment Planning (Outcome Measure 15) during the third quarter. The initial review included 35 cases. Subsequent quarterly reviews will include 70 cases. The findings for the initial review of these measures are contained later in the report (Third Quarter 2006 Case Review for Outcome Measure 3 and Outcome Measure 15). The review confirms that DCF remains challenged to meet the placement, permanency and treatment needs for a number of children it serves. The Monitor is reserving specific comment on emerging issues and trends until next quarter when data for a full sample (70 cases) will be available.

[1] The Defendants must be in compliance with all of the outcome measures, and in sustained compliance with all of the outcome measures for at least two consecutive quarters (six months) prior to asserting compliance and shall maintain compliance through any decision to terminate jurisdiction.

6. The Department sustained compliance with Reduction in Residential Care (Outcome Measure 19) for a second quarter. There are 250 fewer children placed in residential care than in the second quarter of 2004.

7. The Monitor has continued to participate in the ongoing program review at Riverview Hospital. A report by the Department's Program Review team is due for dissemination in mid-December. The Department has committed to developing a work plan in response to the recommendations of the program review team, consultative teams, and Riverview staff.

The Department's full, unedited, but verified report to the Court Monitor is incorporated at the end of this Monitor's Report to the Court.

3Q July 1-September 30, 2006 Exit Plan Report
Outcome Measure Overview

Measure	Measure	Baseline	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005	1Q 2006	2Q 2006	3Q 2006
1: Investigation Commencement	>=90%	X	X	X	X	91.2%	92.5%	95.1%	96.2%	96.1%	96.2%	96.4%	98.7%
2: Investigation Completion	>=85%	73.7%	64.2%	68.8%	83.5%	91.7%	92.3%	92.3%	93.1%	94.2%	94.2%	93.1%	94.2%
3: Treatment Plans**	>=90%	X	X	X	10%	17%	X	X	X	X	X	X	54%
4: Search for Relatives*	>=85%	58%	93%	82%	44.6%	49.2%	65.1%	89.6%	89.9%	93.9%	93.1%	2/15/07*	5/15/07*
5: Repeat Maltreatment	<=7%	9.3%	9.4%	8.9%	9.4%	8.9%	8.2%	8.5%	9.1%	7.3%	6.3%	7.0%	7.9%
6: Maltreatment OOH Care	<=2%	1.2%	0.5%	0.8%	0.9%	0.6%	0.8%	0.7%	0.8%	0.6%	0.4%	0.7%	0.8%
7: Reunification*	>=60%	57.8%	X	X	X	X	X	X	64.2%	61%	66.4%	64.4%	62.5%
8: Adoption	>=32%	12.5%	10.7%	11.1%	29.6%	16.7%	33%	25.2%	34.4%	30.7%	40.8%	36.9%	27%
9: Transfer of Guardianship	>=70%	60.5%	62.8%	52.4%	64.6%	63.3%	64.0%	72.8%	64.3% *	72.4%	60.7%	63.1%	70.2%
10: Sibling Placement*	>=95%	57%	65%	53%	X	X	X	X	96%	94%	75%	77%	83%
11: Re-Entry	<=7%	6.9%	X	X	X	X	X	X	7.2%	7.6%	6.7%	7.5%	4.3%
12: Multiple Placements	>=85%	X	X	95.8%	95.2%	95.5%	96.2%	95.7%	95.8%	96%	96.2%	96.6%	95.6%
13: Foster Parent Training	100%	X	X	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
14: Placement Within Licensed Capacity	>=96%	94.9%	88.3%	92.0%	93.0%	95.7%	97%	95.9%	94.8%	96.2%	95.2%	94.5%	96.7%
15: Needs Met	>=80%	X	53%	57%	53%	56%	X	X	X	X	X	X	62%
16: Worker-Child Visitation (OOH)*	>=85% 100%	Monthly Quarterly	72% 87%	86% 98%	73% 93%	81% 91%	77.9% 93.3%	86.7% 95.7%	83.3% 92.8%	85.6% 91.9%	86.8% 93.1%	86.5% 90.9%	92.5% 91.5%
17: Worker-Child Visitation (IH)*	>=85%	X	39%	40%	46%	33%	X	81.9%	78.3%	85.6%	86.2%	87.6%	85.7%
18: Caseload Standards+	100%	69.2%	73.1%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%
19: Residential Reduction	<=11%	13.5%	13.9%	14.3%	14.7%	13.9%	13.7%	12.6%	11.8%	11.6%	11.3%	10.8%	10.9%
20: Discharge Measures	>=85%	61%	74%	52%	93%	83%	X	X	96%	92%	85%	91%	100%
21: Discharge to DMHAS and DMR	100%	X	43%	64%	56%	60%	X	X	78%	70%	95%	97%	100%
22: MDE	>=85%	5.6%	19.0%	24.5%	48.9%	44.7%	55.4%	52.1%	54.6%	72.1%	91.1%	89.9%	86%

Monitor's Office Case Review for Outcome Measure 3 and Outcome Measure 15

I. Background and Methodology:

The *Juan F.* v Rell Revised Exit Plan and subsequent stipulated agreement reached by the parties and court ordered on July 11, 2006 requires the Monitor's Office to conduct a series of quarterly case reviews to monitor Outcome Measure 3 – Treatment Planning and Outcome Measure 15 – Needs Met. The implementation of this review began with a sample of 35 cases during the third quarter 2006. The Monitor's Office will review a total of 70 cases in each subsequent calendar quarter.

On the first Monday of the month prior to the start of a calendar quarter, the caseloads for the area offices will be identified using the DCF LINK Caseload Detail Report. The 70 case sample will be stratified based upon the distribution of area office caseload. Since there are caseload shifts over time, this process will reflect the changes that may occur. The sample will incorporate both in-home and out-of-home cases based on the overall statewide percentage reflected at the point that each sample is determined.

The methodology required the pairing of DCF staff with Monitor's Review staff. Seven two member teams were selected for the quarter's reviews. Third Quarter Teams consisted of the following pairings:

Monitor's Staff	DCF Staff
Mary Corcoran	Barbara O'Connell
Tom Gallese	Deb Collins/Fred North
MaryAnn Hartmann	Sandra Tapia
Ray Mancuso	Juliann Harris
Susan Marks-Roberts	Kathy Acosta
Joni Beth Roderick	Liz Cyr
Michelle Turco	Jorge Martinez

We wish to thank all participants for their efforts during this process. The collaboration of Monitor and DCF staff is a means to further develop internal quality assurance resources as well as improve reliability. A team process will continue into the 4th quarter process, but may be changed in future reviews as referenced below.

Our process is four fold and incorporates an inter-rater procedure to monitor the validity and reliability of the protocol and reviewers. Each review takes approximately 7 hours to 12 hours depending upon the circumstances and complexity of the case assigned. The process entails:

1. A review of the Case LINK Record documentation for each sample case concentrating on the most recent six months. This includes narratives, treatment planning documentation, investigation protocols, and the provider narratives for any foster care provider during the last six-month period.
2. Attendance/Observation at the Treatment Planning Conference (TPC)/Administrative Case Review (ACR) or Family Conference (FC).

3. A subsequent review of the final approved plan that resulted from the meeting attended will be conducted fourteen to twenty days following attendance at the TPC/ACR/FC. The reviewers then complete an individual assessment of the treatment plan and needs met outcome measures and fill out the scoring forms for each.
4. A final meeting with the assigned teammate is held to jointly arrive at the final scores for each section and overall scoring for OM3 and 15. Individual scoring and joint scoring forms are then submitted to the Monitor. (This step may change as determined appropriate by the DCF Court Monitor after evaluation of the inter-rater findings and fiscal/staffing considerations.)

Although the criterion for scoring requires consistency in definition and process to ensure validity, no two treatment plans will look alike. Each case has unique circumstances that must be factored into the decision making process. Each reviewer has been provided with direction to evaluate the facts of the case in relationship to the standards and considerations and have a solid basis for justifying the scoring.

In situations where agreement cannot be reached, the team requests that the supervisor become a third voice on those areas of concern. They present their opinions and findings and the supervisor determines the appropriate score to reflect the level of performance for the specific item(s) and assists them in the overall determination of compliance for OM3 and OM15. If the team indicates that there are areas that do not attain the "very good" or "optimal" level, yet consensus is the overall score should be "an appropriate treatment plan" or "needs met" the team clearly outlines their reasoning for such a determination and it is reviewed by the Court Monitor for approval of an override exception. These cases are also forwarded to the Technical Advisory (TAC) for review.

Several cases resulted in submittal to the project supervisors regarding possible overrides. Five of the submitted cases were overridden using the process detailed above. The five included two situations in which OM3 was found to be appropriate, and 3 situations in which OM15 was found to have met needs despite a score less than 4 "Very Good" for a category of measurement.

To assist in determining reliability and validity, all individual documents were collected and each pairing of individual reviewers were scored using inter-rater tools within the SPSS data system. Due to the low number of cases reviewed per team, strict percentage agreement scores did not offer much insight into reliability. Where applicable, mean scores using intraclass correlation (ICC) were looked at within and across all teams' responses to the categorical ranking questions of each measure. While individual teams varied in the level of response, the overall mean indicated a generally acceptable performance as a whole. The general acceptable score for ICC is 0.70. As a rule:

- Score of 0.80 +: Outstanding Reliability
- Score of 0.60 to 0.79: Substantial Reliability

- Score of 0.40 to 0.59: Moderate Reliability
- Score of <0.40: Less than Moderate Reliability

Our results for the third quarter provide a mean average across all teams for the rankings for OM3 from .422 (Progress) to .829 (OM3 – Overall Score). All but the lowest mean score for OM3 fell into the range of substantial or outstanding reliability (.60 or higher).

Mean average ICC scores for the rankings of OM15 ranged from .330 (Dental) to 1.00 (Safety – Children in Placement, DCF Case Management – Recruitment, and Children's Current Placement). All but three of the mean scores for OM15 fell into the range of substantial or outstanding reliability (.60 or higher).

To address the areas of disparity, a post review team meeting was held in October to address individual reviewer's and teams' issues related to the review process. Clarifications were provided, and a better understanding of some of the finer points of the process resulted from this trial review process and debriefing. A sample case was jointly reviewed by all reviewers and then each subcategory was analyzed. As necessary, additional training and clarification will be ongoing throughout the process including revisions to the instructions.

Reviewers will be reassigned to various teams/office locations so that no office has the same team consistently reviewing their cases every quarter.

II. Third Quarter 2006 Sampling

Using the methodology outlined above, the caseload was established on June 5, 2006. A sample of 35 cases was selected for this trial review based upon the percentage of cases by area office and case type (in home/children in placement). This resulted in the following distribution of cases:

Table 1: Area Office Designation of the Sample Set (n=35)

Area Office	In-Home	Child In Placement	Total Sample
Bridgeport	1	2	3
Danbury	0	1	1
Greater New Haven	1	2	3
Hartford	1	3	4
Manchester	1	3	4
Meriden	0	1	1
Middletown	0	1	1
New Britain	1	2	3
New Haven Metro	1	3	4
Norwalk	0	1	1
Norwich	1	2	3
Stamford	0	1	1
Torrington	0	1	1
Waterbury	1	2	3
Willimantic	0	2	2
Statewide	8	27	35

While many demographic or descriptive elements were captured for this sample, given the small sample size we find it unnecessary to report on each element. Some key elements of interest are detailed below.

Sample cases were identified by Assignment Type. At the point of review, the data indicates that the majority of cases (71.4%) are children in care for child protective service reasons. Of the children in placement, four children (14.3%) had some involvement with the Juvenile Justice System. A full description of the sample is provided below:

Table 2: Case Assignment Types with the Sample Set (n=35)

Assignment	Frequency	Percent	Cumulative Percent
CPS In-Home Family	6	17.1	17.1
CPS Child in Placement	25	71.4	88.6
Voluntary Services In-Home Family	1	2.9	91.4
Voluntary Services Child in Placement	2	5.7	97.1
Associated Family to Child in Placement (CPS)[2]	1	2.9	100.0
Total	35	100.0	

In establishing the reason for the most recent case open date identified, reviewers were asked to identify all substantiations or voluntary service needs identified at the point of most recent case opening. The data indicates that physical neglect is the most frequent reason for a case opening in treatment, as 54.3% of the cases cited this as one of the factors for the case opening. This was followed by Parental Substance Abuse/Mental Health which was present in 34.3% of the cases reviewed, and Emotional Neglect, which was identified in 31.4% of the cases reviewed. When asked to isolate the primary reason for case opening among those identified for each case; physical neglect was identified for 40% of the sample set. This was followed by the child's TPR requiring case opening under the child's name (17.1%) and domestic violence (8.6%).

[2] One case selected as an in-home case had child come into care shortly after the family conference was held. This is reflected as a difference of 1 in some charts (8 vs. 7) depending upon the time frame and focus of the question.

Table 3: Reasons for DCF Involvement at Point of Most Recent Case Opening (n=35)

Reason	Frequency	Frequency with which Reason was Cited as Primary Cause
Abandonment	1	1 (death of adoptive parent)
Child's TPR	7	6
Domestic Violence	9	3
Educational Neglect	4	1
Emotional Neglect	11	0
Medical Neglect	2	2
Parental Substance Abuse/Mental Health	12	3
Physical Abuse	3	1
Physical Neglect	19	15
Voluntary Service Request/FWSN	4	3
	72	35

Permanency/case goals were identified for 30 of the 35 cases reviewed (85.7%). Of the seven situations in which reunification was the goal, there was a required concurrent plan documented for five cases (71.4%). Goals for the sample set are provided below. Of those indicated as UTD, two are in-home cases and three are CPS children in placement. All three cases with the goal of APPLA: Other were identified as Independent Living.

Table 4: What is the child or family's stated goal on the most recent approved treatment plan in place during the period?

	Frequency	Percent	Cumulative Percent
Reunification	7	20.0	20.0
Adoption	8	22.9	42.9
Transfer of Guardianship	1	2.9	45.7
Long Term Foster Care with a licensed relative	2	5.7	51.4
APPLA: Permanent Non-Relative Foster Care	4	11.4	62.9
APPLA: Other	3	8.6	71.4
In-Home Goals - Safety/Well Being Issues	5	14.3	85.7
UTD - plan incomplete, unapproved or missing for this period	5	14.3	100.0
Total	35	100.0	

Children in placement had various lengths of stay at the point of our review. This ranged from less than one month, to greater than 24 months. The distribution of length of stays is provided below with an indication of whether TPR has been filed in relation to both the ASFA requirement and overall length of time in care. In nine of the 12 cases indicated

below, TPR had been granted prior to our review. There were no children exceeding the time frame for which either TPR or Compelling Reason had not been filed with the court.

Crosstabulation 1: Has child's length of stay exceeded the 15 of the last 22 benchmark set by ASFA? * For child in placement, has TPR been filed?

	For child in placement, has TPR been filed?					Total
Has child's length of stay exceeded the 15 of the last 22 benchmark set by ASFA?	**yes**	**no**	**N/A – Compelling Reason noted in LINK**	**N/A - child's goal and length of time in care don't require**	**N/A - In-Home Case (CPS or Voluntary Services)**	
yes	1	0	5	0	0	6
no	2	1	1	9	0	13
N/A - In-Home Case (CPS or Voluntary Services)	0	0	0	0	7	7
N/A - TPR has already been filed and granted	9	0	0	0	0	9
Total	12	1	6	9	7	35

Crosstabulation 2: How many consecutive months has this child been in out of home placement as of the date of this review or date of case closure during the period? * For child in placement, has TPR been filed?

	For child in placement, has TPR been filed?					Total
How many consecutive months has this child been in out of home placement as of the date of this review or date of case closure during the period?	**yes**	**no**	**N/A – Compelling Reason**	**N/A - child's goal and length of time in care don't require**	**N/A - In-Home Case (CPS or Voluntary Services)**	
Less than one month	0	0	0	1	0	1
1-6 months	0	0	0	3	0	3
7-12 months	0	0	0	2	0	2
13-18 months	3	1	1	3	0	8
Greater than 24 months	9	0	5	0	0	14
N/A - no child in placement (in-home case)	0	0	0	0	7	7
Total	12	1	6	9	7	35

III. Monitor's Findings Regarding Outcome Measure 3 – Treatment Plans

Outcome Measure 3 requires that, *"in at least 90% of the cases, except probate, interstate and subsidy only cases, appropriate treatment plans shall be developed as set forth in the "DCF Court Monitor's 2006 Protocol for Outcome Measures 3 and 15" dated June 29, 2006 and the accompanying "Directional Guide for OM3 and OM15 Reviews" dated June 29, 2006."*

The case review data indicates that the Department of Children and Families attained the level of "Appropriate Treatment Plan" in 54.3% of the 35 case sample. Five of the plans not passing did not have social work supervisory approval. Of those five, three would have passed based on the quality of the plan, had the approval been documented. All 35 cases (100%) had families' language needs met. Two cases had plans greater than 7 months old at the point of review as a result of the failure of the social work supervisor to approve the plan.

While the sample size is small, it is notable that the percentage of "not appropriate" plans for in-home cases (both CPS and Voluntary) is a great deal higher than those of children in placement. Of the eight cases selected as in-home family cases, only 1 case (12.5%) achieved "appropriate treatment plan" status. Eighteen of the 27 children in placement cases (both CPS and Voluntary) achieved "appropriate treatment plan" status (66.7%).

Crosstabulation 3: What is the type of case assignment noted in LINK? * Overall Score for OM3

What is the type of case assignment noted in LINK?	Overall Score for OM3		Total
	Appropriate Treatment Plan	Not an Appropriate Treatment Plan	
CPS In-Home Family Case (IHF)	1	5	6
CPS Child in Placement Case (CIP)	16	9	25
Voluntary Services In-Home Family Case (VSIHF)	0	1	1
Voluntary Services Child in Placement Case (VSCIP)	2	0	2
Associated CIP Family Case (ACIPF)	0	1	1
Total	19	16	35

The review examined the level of engagement with children, families and providers in the development of the treatment plans as well as the content of the plan document itself. Each case had a unique pool of active participants for DCF to collaborate with in the process. The chart below indicates the degree to which identifiable/active case participants were engaged by the social worker and the extent to which these participants

attended the TPC/ACR/FC. Percentages reflect the level or degree to which a particular participant was part of the treatment planning efforts across all the cases reviewed.

Table 5: Participation and Attendance Rates for Active Case Participants within the Sample Set

Identified Case Participant	Percentage Participating/Engaged in Treatment Planning Discussions	Percentage Attending the ACR or Family Conference
Child	85.7%	55.5%
Mother	60.0%	42.9%
Father	40.0%	20.0%
Foster Parent	54.3%	25.7%
Service Provider	82.5%	42.1%
Attorney/GAL (Child)	50.0%	3.7%
Parents' Attorney	35.3%	5.9%
Other DCF Staff	84.0%	56.0%
Other Participants	94.4%	72.2%

The review process looked at eight categories of measurement when determining overall appropriateness of the treatment planning. Scores were based upon the following rank/scale.

Optimal Score – 5
The reviewer finds evidence of all essential treatment planning efforts for both the standard of compliance and all relevant consideration items (documented on the treatment plan itself).

Very Good Score – 4
The reviewer finds evidence that essential elements for the standard of compliance are substantially present in the final treatment plan and may be further clarified or expanded on the DCF 553 (where latitude is allowed as specified below) given the review of relevant consideration items.

Marginal Score – 3
There is an attempt to include the essential elements for compliance but the review finds that substantial elements for compliance as detailed by the Department's protocol are not present. Some relevant considerations have not been incorporated into the process.

Poor Score – 2
The reviewer finds a failure to incorporate the most essential elements for the standard of compliance detailed in the Department's protocol. The process does not take into account the relevant considerations deemed essential, and the resulting document is in conflict with record review findings and observations during attendance at the ACR.

Absent/Adverse Score – 1
The reviewer finds no attempt to incorporate the standard for compliance or relevant considerations identified by the Department's protocol. As a result there is no treatment plan less than 7 months old at the point of review or the process has been so poorly performed that it has had an adverse affect on case planning efforts. "Reason for Involvement" and "Present Situation to Date" were most frequently ranked with an Optimal Score. Deficits were most frequently noted in two of the eight categories: "Determination of Goals/Objectives" and "Action Steps to Achieve Goals". The following table provides the scoring for each category for the sample set and the corresponding percentage of cases within the sample that achieved that ranking.

For a complete listing of rank scores for Outcome Measure 3 by case, see Appendix 1.

Table 6: Measurements of Treatment Plan OM 3 – Percentage of Rank Scores Attained Across All Categories

Category	# Ranked Optimal "5"	# Ranked Very Good "4"	# Ranked Marginal "3"	# Ranked Poor "2"	# Ranked Adverse/Absent "1"
I.1 Reason for DCF Involvement	17 (48.6%)	17 (48.6%)	1 (2.9%)	0	0
I.2. Identifying Information	9 (25.7%)	18 (51.4%)	6 (17.1%)	1 (2.9%)	1 (2.9%)
I.3. Strengths/Needs/Other Issues	9 (25.7%)	22 (62.9%)	3 (8.6%)	0	1 (2.9%)
I.4. Present Situation and Assessment to Date of Review	13 (37.1%)	16 (45.7%)	5 (14.3%)	0	1 (2.9%)
II.1 Determining the Goals/Objectives	7 (20.0%)	17 (48.6%)	9 (25.7%)	1 (2.9%)	1 (2.9%)
II.2. Progress[3]	5 (14.3%)	24 (68.6%)	5 (14.3%)	0	0
II.3 Action Steps to Achieving Goals Identified	4 (11.4%)	20 (57.1%)	9 (25.7%)	1 (2.9%)	1 (2.9%)
II.4 Planning for Permanency	12 (34.3%)	15 (42.9%)	6 (17.1%)	1 (2.9%)	1 (2.9%)

[3] One case was newly opened – ranked as N/A too early to note progress (2.9%).

IV. Monitor's Findings Regarding Outcome Measure 15 – Needs Met

Outcome Measure 15 requires that, *"at least 80% of all families and children shall have all their medical, dental, mental health and other service needs met as set forth in the "DCF Court Monitor's 2006 Protocol for Outcome Measures 3 and 15 dated June 29, 2006, and the accompanying 'Directional Guide for OM3 and OM15 Reviews dated June 29, 2006."*

The case review data indicates that the Department of Children and Families attained the designation of "Needs Met" in 62.9% of the 35 case sample. The percentage of "needs not met" plans for in-home cases (both CPS and Voluntary) is a slightly higher than those selected as children in placement cases. Of the eight cases selected as in-home family cases, 4 cases (50.0%) achieved "needs" status. Twenty-two of the 27 cases with children in placement (both CPS and Voluntary) achieved "needs met" status (66.7%).

Outcome Measure 15 looked at twelve categories of measurement to determine the level with which the Department was able to meet the needs of families and children. All categories are in table seven below with the frequency and percentage of applicable cases achieving each rank score below.

For a complete listing of rank scores for Outcome Measure 15 by case, see Appendix 1.

Crosstabulation 4: What is the type of case assignment noted in LINK? * Overall Score for Outcome Measure 15

What is the type of case assignment noted in LINK?	Overall Score for Outcome Measure 15		Total
	Needs Met	Needs Not Met	
CPS In-Home Family Case (IHF)	3	3	6
CPS Child in Placement Case (CIP)	17	8	25
Voluntary Services In-Home Family Case (VSIHF)	1	0	1
Voluntary Services Child in Placement Case (VSCIP)	1	1	2
Associated CIP Family Case (ACIPF)	0	1	1
Total	22	13	35

Table 7: Measurements of Treatment Plan OM 15 – Percentage of Rank Scores Attained Across All Categories[4]

Category	# Ranked Optimal "5"	# Ranked Very Good "4"	# Ranked Marginal "3"	# Ranked Poor "2"	# Ranked Adverse/Absent "1"	N/A To Case Reviewed
I.1 Safety – In Home	0	10 (100.0%)	0	0	0	25
I.2. Safety – Children in Placement	13 (46.4%)	14 (50.0%)	1 (3.6%)	0	0	7
II.1 Securing the Permanent Placement – Action Plan for the Next Six Months	14 (48.3%)	12 (41.4%)	3 (10.3%)	0	0	6
II.2. DCF Case Management – Legal Action to Achieve the Permanency Goal During the Prior Six Months	14 (40.0%)	17 (48.6%)	4 (11.4%)	0	0	0
II.3 DCF Case Management – Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months	14 (58.3%)	6 (25.0%)	4 (16.7%)	0	0	11
II.4. DCF Case Management – Contracting or Providing Services to achieve the Permanency Goal during the Prior Six Months	11 (31.4%)	19 (54.3%)	5 (14.3%)	0	0	0
III.1 Medical Needs	15 (42.9%)	16 (45.7%)	4 (11.4%)	0	0	0
III.2 Dental Needs	23 (67.6%)	6 (17.6%)	4 (11.8%)	0	1 (2.9%)	1
III.3 Mental Health, Behavioral and Substance Abuse Services	18 (51.4%)	13 (37.1%)	4 (11.4%)	0	0	0
IV.1 Child's Current Placement	16 (55.2%)	11 (37.9%)	2 (6.9%)	0	0	6
IV. 2 Educational Needs	18 (51.4%)	15 (42.9%)	2 (5.7%)	0	0	0

[4] Percentages are based on applicable cases for the individual measure. Those cases marked N/A are excluded from the denominator. At the point of sampling, the total number identified as in-home was 8 cases. However, the number of cases with in-home status at some point during the six month period of review totals 10 cases. Additionally, post sampling, one of the in-home cases converted to child in placement - OOH status with a removal of the child, and one child was living with grandparents (not licensed) who were considering TOG (reducing the N/A category for IV.1 current placement to 6). These facts account for the slight fluctuation in numbers that can be seen within the table on page 18.

In addition to looking at the twelve categories of Outcome Measure 15, the review also collected data on situations in which a case had a need identified at the prior ACR, treatment plan or within the period's LINK record. Data was collected on those that remained unresolved at the point of the most recent treatment planning efforts. In 19 of the 35 cases, the reviewers identified at least one unmet need. In all there were 35 needs unmet at the point of the review. These included:

Table 8: Unmet Service Needs Identified within 19 of the Sample Set Cases

Service Need	Frequency
Mental Health Treatment	7
Dental	5
Out of Home Support Service	5
Domestic Violence Services	3
Housing	3
Substance Abuse Treatment	3
Medical Services	2
In-Home Support Service	2
Educational Services	2
Out of Home Care	1
DCF Case Management	1
Training	*1*
Total Unmet Needs	35

Barriers were identified for the unmet needs cited above. Most frequently (37.1%) the barrier was identified as client refusal. All those identified are included with the level of frequency in the table below:

Table 9: Barriers Identified for Unmet Service Needs with the 19 Sample Set Cases Having One or More Unmet Needs

Barrier	Frequency
Client Refusal	13
Delay in Referral	4
Insurance Issues	4
Other[5]	4
UTD	3
Service Deferred Pending Completion of Another	2
Provider Unwilling to Engage Client	2
No Slots Available	2
Wait List	1

In addition, when looking specifically at the current treatment planning document, ten of the 35 cases (28.6%) had evidence of a service need that was clearly identified at the ACR/TPC or within LINK documentation but not incorporated into the current treatment plan document. These 10 cases included 19 service needs as indicated below:

[5] Other Reasons Included: Dental Provider under Investigation, Therapist failed to make referral, youth's level of functioning precluded service, poor communication DCF/school.

Table 10: Service Needs Not Incorporated into the Treatment Plan Documentation of Ten Sample Set Cases

Service Need	Frequency
Dental	4
Out of Home Support Service	3
Substance Abuse Treatment	3
Mental Health Treatment	2
Medical Services	2
DCF Case Management	2
Domestic Violence Services	1
Housing	1
In-Home Support Service	1
Total	19

It is important to note that while 19 needs were not incorporated into the treatment planning documents, in several cases reviewers felt that the ACR/TPC/FC discussions adequately addressed case work, and the responsibility of participants toward meeting the need.

Appendix 1

Rank Scores for Outcome Measure 3 & 15

Appendix 2

The Department's Exit Plan Outcome Measures Summary Report Third Quarter 2006
July 1, 2006 – September 30, 2006

Case Summaries for OM3[a]

	Has the treatment plan been approved by the SWS?	Reason for DCF Involvement	Identifying Information	Strengths, Needs and Other Issues	Present Situation and Assessment to Date of Review	Determining the Goals/ Objectives	Progress	Action Steps to Achieving Goals Identified for the Upcoming Six Month Period	Planning for Permanency	Overall Score for OM3
1	yes	Very Good	Very Good	Marginal	Marginal	Marginal	Marginal	Marginal	Marginal	Not an Appropriate Treatment Plan
2	yes	Very Good	Optimal	Very Good	Optimal	Very Good	Very Good	Very Good	Optimal	Appropriate Treatment Plan
3	yes	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Appropriate Treatment Plan
4	yes	Optimal	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Very Good	Appropriate Treatment Plan
5	yes	Optimal	Very Good	Very Good	Optimal	Very Good	Optimal	Very Good	Very Good	Appropriate Treatment Plan
6	yes	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Appropriate Treatment Plan
7	yes	Optimal	Optimal	Optimal	Optimal	Very Good	Very Good	Very Good	Optimal	Appropriate Treatment Plan
8	yes	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Very Good	Optimal	Appropriate Treatment Plan
9	yes	Very Good	Marginal	Marginal	Marginal	Marginal	Marginal	Poor	Poor	Not an Appropriate Treatment Plan
10	yes	Very Good	Marginal	Very Good	Very Good	Very Good	Very Good	Marginal	Very Good	Appropriate Treatment Plan
11	yes	Very Good	Very Good	Very Good	Very Good	Optimal	Very Good	Optimal	Optimal	Appropriate Treatment Plan
12	yes	Optimal	Optimal	Very Good	Optimal	Marginal	Very Good	Marginal	Very Good	Not an Appropriate Treatment Plan
13	yes	Optimal	Marginal	Very Good	Optimal	Very Good	Very Good	Very Good	Optimal	Appropriate Treatment Plan
14	no	Very Good	Marginal	Very Good	Very Good	Poor	Very Good	Marginal	Very Good	Not an Appropriate Treatment Plan
15	no	Optimal	Very Good	Optimal	Optimal	Very Good	Very Good	Very Good	Very Good	Not an Appropriate Treatment Plan
16	yes	Very Good	Very Good	Very Good	Optimal	Very Good	Very Good	Very Good	Very Good	Appropriate Treatment Plan
17	yes	Optimal	Very Good	Very Good	Very Good	Optimal	Very Good	Very Good	Very Good	Appropriate Treatment Plan
18	yes	Optimal	Very Good	Very Good	Optimal	Optimal	Very Good	Optimal	Optimal	Appropriate Treatment Plan
19	yes	Very Good	Poor	Marginal	Marginal	Marginal	Marginal	Marginal	Very Good	Not an Appropriate Treatment Plan

Case Summaries for OM3[a]

	Has the treatment plan been approved by the SWS?	Reason for DCF Involvement	Identifying Information	Strengths, Needs and Other Issues	Present Situation and Assessment to Date of Review	Determining the Goals/ Objectives	Progress	Action Steps to Achieving Goals Identified for the Upcoming Six Month Period	Planning for Permanency	Overall Score for OM3
20	no	Optimal	Very Good	Optimal	Very Good	Very Good	Very Good	Very Good	Optimal	Not an Appropriate Treatment Plan
21	no	Optimal	Optimal	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Not an Appropriate Treatment Plan
22	yes	Optimal	Optimal	Very Good	Very Good	Very Good	Very Good	Very Good	Optimal	Appropriate Treatment Plan
23	yes	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Optimal	Appropriate Treatment Plan
24	yes	Very Good	Optimal	Very Good	Very Good	Very Good	Very Good	Marginal	Marginal	Not an Appropriate Treatment Plan
25	yes	Very Good	Marginal	Very Good	Very Good	Marginal	Marginal	Marginal	Optimal	Not an Appropriate Treatment Plan
26	yes	Optimal	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Appropriate Treatment Plan
27	yes	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Appropriate Treatment Plan
28	yes	Very Good	Very Good	Optimal	Very Good	Marginal	Very Good	Marginal	Marginal	Not an Appropriate Treatment Plan
29	yes	Very Good	Very Good	Optimal	Optimal	Very Good	Very Good	Very Good	Marginal	Not an Appropriate Treatment Plan
30	yes	Optimal	Very Good	Very Good	Optimal	Optimal	Optimal	Very Good	Optimal	Appropriate Treatment Plan
31	yes	Very Good	Very Good	Very Good	Marginal	Marginal	Very Good	Very Good	Marginal	Not an Appropriate Treatment Plan
32	yes	Optimal	Very Good	Very Good	Very Good	Marginal	Marginal	Marginal	Marginal	Not an Appropriate Treatment Plan
33	yes	Optimal	Optimal	Optimal	Very Good	Very Good	Very Good	Very Good	Very Good	Appropriate Treatment Plan
34	no	Marginal	Absent/Averse	Absent/Averse	Absent/Averse	Absent/Averse	Too early to note progress	Absent/Averse	Absent/Averse	Not an Appropriate Treatment Plan
35	yes	Optimal	Marginal	Very Good	Marginal	Marginal	Very Good	Very Good	Very Good	Not an Appropriate Treatment Plan
Total N	35	35	35	35	35	35	35	35	35	35

a. Limited to first 100 cases.

Case Summaries for OM 15[a]

	Safety: In-Home	Safety: Child In Placement	Permanency: Securing the Permanent Placement - Action Plan for the Next Six Months	Permanency: DCF Case Mgmt - Legal Action to Achieve the Permenancy Goal During the Prior Six Months	Permanency: DCF Case Mgmt - Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months	Permanency: DCF Case Mgmt - Contracting or Providing Services to Achieve the Permenency Goal during the Prior Six Months	Well-Being: Medical Needs	Well-Being: Dental Needs	Well-Being: Mental Health, Behavioral and Substance Abuse Services	Well-Being: Child's Current Placement	Well-Being: Education	Overall Score for Outcome Measure 15
1	N/A to Case Type	Very Good	Marginal	Marginal	Marginal	Marginal	Optimal	Optimal	Marginal	Marginal	Optimal	Needs Not Met
2	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met
3	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Optimal	Very Good	Optimal	Optimal	Optimal	Optimal	Needs Met
4	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met
5	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met
6	N/A to Case Type	Very Good	Very Good	Very Good	Very Good	Very Good	Marginal	Optimal	Very Good	Very Good	Optimal	Needs Met
7	N/A to Case Type	Optimal	Optimal	Very Good	Optimal	Optimal	Optimal	Marginal	Optimal	Optimal	Optimal	Needs Not Met
8	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met
9	N/A to Case Type	Marginal	Marginal	Very Good	N/A to Case Type	Marginal	Optimal	Optimal	Marginal	Marginal	Very Good	Needs Not Met
10	N/A to Case Type	Very Good	Very Good	Very Good	Optimal	Optimal	Marginal	Optimal	Very Good	Very Good	Very Good	Needs Not Met
11	N/A to Case Type	Optimal	Optimal	Very Good	Optimal	Very Good	Very Good	Very Good	Optimal	Optimal	Optimal	Needs Met
12	N/A to Case Type	Optimal	Marginal	Very Good	Marginal	Very Good	Very Good	Optimal	Optimal	Very Good	Very Good	Needs Not Met
13	N/A to Case Type	Very Good	Optimal	Optimal	N/A to Case Type	Very Good	Very Good	Very Good	Very Good	Optimal	Very Good	Needs Met
14	N/A to Case Type	Very Good	Very Good	Marginal	N/A to Case Type	Very Good	Very Good	Marginal	Optimal	Optimal	Very Good	Needs Not Met
15	N/A to Case Type	Very Good	Very Good	Very Good	Optimal	Very Good	Very Good	Very Good	Optimal	Very Good	Very Good	Needs Met
16	N/A to Case Type	Optimal	Optimal	Very Good	Optimal	Optimal	Very Good	Optimal	Optimal	Optimal	Optimal	Needs Met
17	N/A to Case Type	Optimal	Optimal	Optimal	Very Good	Very Good	Marginal	Optimal	Very Good	Very Good	Marginal	Needs Not Met
18	N/A to Case Type	Optimal	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met
19	Very Good	N/A to Case Type	Very Good	Very Good	N/A to Case Type	Marginal	Very Good	Optimal	Marginal	Very Good	Very Good	Needs Not Met
20	N/A to Case Type	Optimal	Optimal	Optimal	Optimal	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Needs Met
21	Very Good	N/A to Case Type	N/A to Case Type	Very Good	N/A to Case Type	Very Good	Very Good	Optimal	Marginal	N/A to Case Type	Optimal	Needs Not Met
22	Very Good	Very Good	Very Good	Very Good	Marginal	Marginal	Optimal	Very Good	Very Good	Very Good	Optimal	Needs Not Met
23	Very Good	Very Good	Optimal	Very Good	N/A to Case Type	Very Good	Very Good	Optimal	Optimal	Very Good	Optimal	Needs Met
24	Very Good	Very Good	N/A to Case Type	Optimal	N/A to Case Type	Very Good	Very Good	N/A to Case Type	Very Good	N/A to Case Type	Optimal	Needs Met
25	N/A to Case Type	Optimal	Optimal	Optimal	Very Good	Optimal	Optimal	Optimal	Very Good	Optimal	Optimal	Needs Met
26	N/A to Case Type	Very Good	Very Good	Very Good	Marginal	Marginal	Optimal	Optimal	Very Good	Very Good	Marginal	Needs Not Met
27	Very Good	N/A to Case Type	N/A to Case Type	Very Good	N/A to Case Type	Very Good	Very Good	Very Good	Optimal	N/A to Case Type	Very Good	Needs Met
28	Very Good	N/A to Case Type	Very Good	Marginal	Very Good	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Needs Met

Case Summaries for OM 15[a]

	Safety: In-Home	Safety: Child In Placement	Permanency: Securing the Permanent Placement - Action Plan for the Next Six Months	Permanency: DCF Case Mgmt - Legal Action to Achieve the Permenancy Goal During the Prior Six Months	Permanency: DCF Case Mgmt - Recruitment for Placement Providers to achieve the Permanency Goal during the Prior Six Months	Permanency: DCF Case Mgmt - Contracting or Providing Services to Achieve the Permenency Goal during the Prior Six Months	Well-Being: Medical Needs	Well-Being: Dental Needs	Well-Being: Mental Health, Behavioral and Substance Abuse Services	Well-Being: Child's Current Placement	Well-Being: Education	Overall Score for Outcome Measure 15
29	N/A to Case Type	Very Good	Very Good	Optimal	Very Good	Very Good	Optimal	Optimal	Optimal	Optimal	Very Good	Needs Met
30	N/A to Case Type	Very Good	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Very Good	Very Good	Very Good	Needs Met
31	Very Good	N/A to Case Type	N/A to Case Type	Very Good	N/A to Case Type	Very Good	Marginal	Marginal	Very Good	N/A to Case Type	Very Good	Needs Not Met
32	Very Good	N/A to Case Type	N/A to Case Type	Marginal	N/A to Case Type	Very Good	Very Good	Absent/Averse	Very Good	N/A to Case Type	Very Good	Needs Not Met
33	N/A to Case Type	Very Good	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Optimal	Very Good	Needs Met
34	Very Good	N/A to Case Type	N/A to Case Type	Very Good	N/A to Case Type	Very Good	Very Good	Marginal	Very Good	N/A to Case Type	Optimal	Needs Met
35	N/A to Case Type	Very Good	Very Good	Very Good	Very Good	Very Good	Very Good	Optimal	Optimal	Optimal	Very Good	Needs Met
Total N	35	35	35	35	35	35	35	35	35	35	35	35

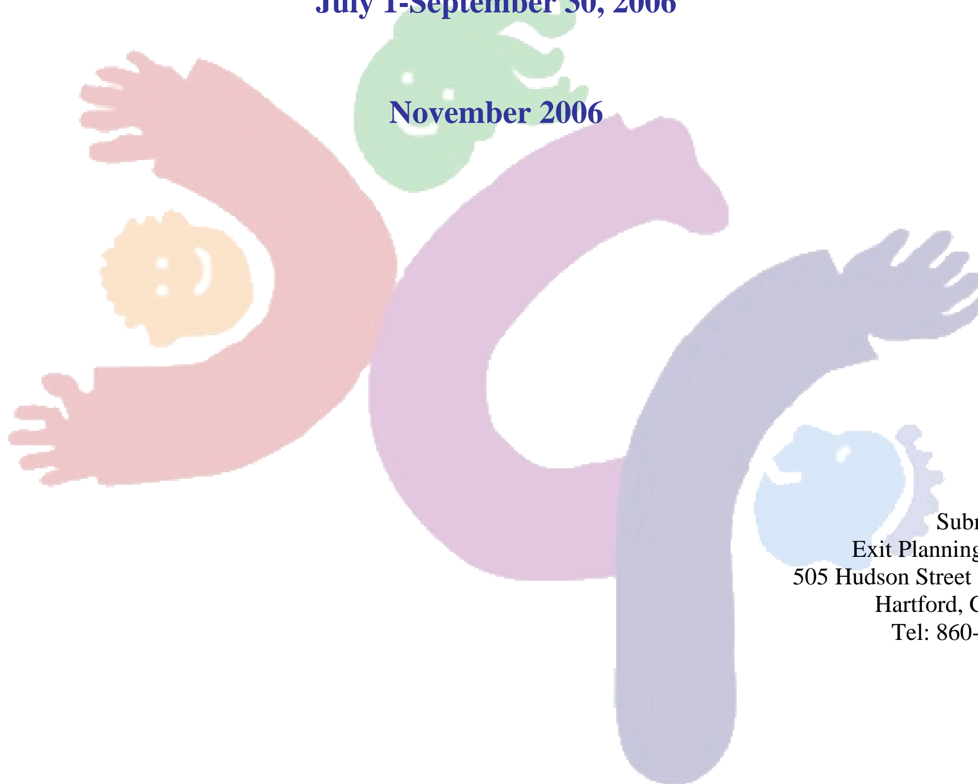
a. Limited to first 100 cases.

Juan F. v Rell
Exit Plan

Civil Action No. H-89-859 (AHN)

Exit Plan Outcome Measures
Summary Report
Third Quarter 2006
July 1-September 30, 2006

November 2006



Submitted by:
Exit Planning Division
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Tel: 860-550-6300

Exit Plan Outcome Measures
Summary Report
Third Quarter 2006

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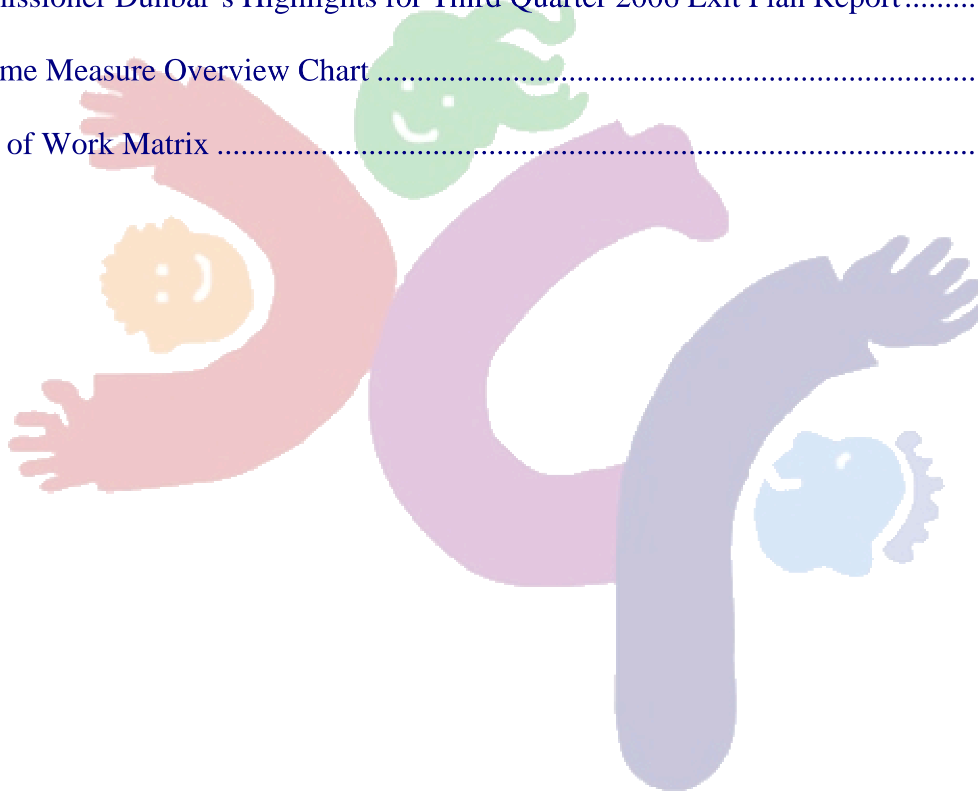


November 18, 2006

Ray Mancuso
Court Monitor
DCF Court Monitor's Office
300 Church Street
Wallingford, CT 06492

Dear Mr. Mancuso,

We are pleased to submit our Third Quarter 2006 Exit Plan Report marking our most successful quarter and signifying real and focused work on improving services to the children and families of Connecticut. Out of the 22 reported measures, the Department met 17 measures. For the first time under the Exit Plan, the Department met the goal of 100% ensuring that mentally ill and mentally retarded youth are discharged appropriately to adult services. For the second time in a row the Department demonstrated success in reducing reliance on residential placements, showing great focus and commitment with this most challenging area of our work.

As you know, this was also the first quarter measuring 3 (treatment planning) and 15 (needs met) using the new case review tool developed by all parties to the case. Currently, 16 of the outcome measures are automated reports. In the Third Quarter 2006 Exit Plan Report, EPOMS: 3, 10, 13, 15, 20 and 21 remain case reviews. For the next reporting period, the Department is prepared to move EPOM 10 (sibling placement) to an automated report.

As with our past Quarterly Exit Reports we continue to conduct supplemental case reviews for EPOM 8 and 9 that identify met or not met outcomes for the n/a cases. We have expanded this practice and have randomly reviewed cases for several other EPOMs to assure the quality and accuracy of our reporting. For the Third Quarter Report a full case review (of all 136 cases) for EPOM 9 (TOG) was conducted in order to best identify and address data entry errors that were apparent. In addition, we also reviewed cases for EPOM 16, 17 and 22. The result of these reviews are summarized in the footnote section of the Quarterly Data Table. The back-up data has been forwarded to you for your confirmation and shows the total number of cases reviewed for this quarter.

The Department staff continues to set an example of high standards for practice and the data and case reviews are confirming the benefits of this focus. We acknowledge that we still have much work to do and that the basis for true quality improvement is contingent upon our continued evaluation and enhancement of our work with children and families.

Respectfully,

Darlene Dunbar, MSW
Commissioner

Third Quarter 2006 Exit Plan Report
Commissioner Highlights

As we near the end of the third year under the Juan F. Exit Plan, it becomes increasingly clear that the value of this reform lies well beyond 22 statistical measures and now extends into widespread practice changes that are becoming institutionalized in the work of our staff. Department staff continue to demonstrate not only that they are improving and sustaining performance as measured by the Exit Plan Outcome Measures – but that the values that stand behind the measures are the same values staff operationalize in their work. This cultural shift promises to impact our social work practice in ways that will reach beyond the 22 outcomes. Workers now don't just talk about meeting "benchmarks" – but rather about the underlying principles they represent: supporting and working as partners with families; thorough assessments and planning; meeting individualized needs; achieving permanency; maintaining safety; and enhancing well-being for all children.

This internalizing of the values represented by outcome measures and the reflection of those values in practice has become so common that sometimes "the numbers" fail to tell the whole story of the changes that have taken place. For example, recently a 17 year old boy who had been in care many years was adopted. Staff never gave up on finding permanency for this youth although the adoption was not finalized to meet the timeliness of adoption outcome measure. Being timely with any adoption is a core value of the Department, but when that can't be achieved, what matters most for staff and the Department is that the adoption succeeded, just as it did for this adolescent boy.

Although the importance of the reform goes well beyond the numbers, the numbers demonstrate sustained progress. During the 3rd Quarter of 2006, Department staff met 17 outcomes – the highest number to date. (Two years ago, 4 outcomes were attained, and one year ago, 9 outcomes were met.) The goals for the appropriate discharge for children with mental health needs and mental retardation was met for the first time this quarter. Six outcomes recorded the highest performance ever over the 11 quarters of the Exit Plan, and another three outcomes matched highs established in previous quarters.

But more important than any one-time achievement is that staff continue to show sustained high level of performance. A dozen measures have been met for three or more consecutive quarters. Five outcomes have been met for eight or more consecutive quarters. Staff continue to demonstrate that when a goal is met, they can continue to perform at high levels over the long term. Improvements have become ingrained in practice, and staff deserve great credit for their enthusiastic embrace of the principles behind the measures. It is impressive to see the determination of staff in consolidating advances already made even while they are asked to do more in other areas of our work such as family conferencing and treatment planning.

But although staff have made a great deal of progress, they fully recognize that significant challenges remain. Everyone who works at the Department knows that professionals who serve children and families can never be fully satisfied with every intervention. There is always more to do and more to do better. And, it is with this in mind that the current accomplishments and challenges are presented below.

ACCOMPLISHMENTS

This quarterly report shows we met the following 17 outcomes:

- Commencement of Investigations: The goal of 90 percent was exceeded for the eighth quarter in a row with a current achievement of 98.7 percent, the highest since measurement began for the Exit Plan in the Fourth Quarter of 2004.
- Completion of Investigations: Workers completed investigations in a timely manner in 94.2 percent of cases, also exceeding the goal of 85 percent for the eighth consecutive quarter. This tied the highest percentage ever for this measure.
- Search for Relatives: For the fourth consecutive quarter time, staff achieved the 85 percent goal for relative searches and met this requirement for 93.1 percent of children.
- Maltreatment of Children in Out-of-Home Care: The Department sustained achievement of the goal of 2 percent or less for the eleventh consecutive quarter with an actual measure of 0.8 percent.
- Timely Reunification: For the fifth consecutive quarter, this measure exceeded the 60 percent goal with a mark of 62.5 percent.
- Timely Transfer of Guardianship: For the third of the last six quarters, staff exceeded the 70 percent goal with 70.2 percent for achieving a transfer within two years of a child's removal.
- Re-entry into Care*:* For the second of the last three quarters, staff exceeded the 7 percent goal for re-entry into care with an actual rate of 4.3 percent – the lowest since the beginning of measurement for this outcome.
- Multiple Placements: For the tenth consecutive quarter, the Department exceeded the 85 percent goal with a rate of 95.6 percent, also the best performance recorded under the Exit Plan.
- Foster Parent Training: For the tenth consecutive quarter, the Department met the 100 percent goal.
- Placement within Licensed Capacity*:* For the third quarter under the Exit Plan, staff met the 96 percent goal with an actual rate of 96.6 percent.
- Worker-To-Child Visitation In Out Of Home Cases: Staff reached their highest level of performance ever and exceeded the 85 percent goal for visitation of children in out-of-home cases for the fourth consecutive quarter by hitting the mark in 92.5 percent of applicable cases.
- Worker to Child Visitation in In-Home Cases: For the fourth consecutive quarter, workers met required visitation frequency in 85.7 percent of cases, thereby exceeding the 85 percent standard. The percent of in-home cases where visitation standards were met has more than doubled since the Exit Plan measures began at the start of 2004.
- Caseload Standards: For the tenth consecutive quarter, no Department social worker carried more cases than the Exit Plan standard.
- Reduction in Residential Care: For the second consecutive quarter, staff kept the share of children in DCF care who are in a residential placement to less than 11 percent. As of November 12, 2006, there were 234 fewer children in residential care than in April 2004 – a reduction of 26.3 percent.
- Discharge Measures: For the fifth consecutive quarter and the sixth time overall under the Exit Plan, staff met the 85 percent goal for ensuring children discharged

at age 18 from state care had attained either educational and/or employment goals by achieving an appropriate discharge in 100 percent of applicable cases. This is the highest performance in this measure in the Exit Plan's history.

- Discharge of Mentally Ill and Mentally Retarded children: Staff also attained 100 percent in this measure of the appropriateness of discharge for children with these special needs for the first time under the Exit Plan and met the Exit Plan goal for the first time ever.
- Multi-disciplinary Exams: For the third consecutive quarter, staff met the 85 percent goal by ensuring that 86 percent of children entering care received a timely multi-disciplinary exam.

While it is satisfying that we met 17 goals in the quarter and more than any previous quarter, most important is that we are sustaining previous measures. One of the most difficult to meet and one that has received much attention and energy is in balancing our reliance on residential placements in relation to other types of placements. Having reduced the reliance upon residential placements and staying below an 11 percent goal for the second consecutive quarter demonstrates that structural and service developments, as well as practice changes, have a sustained impact.

The Managed Service Systems in each area office and in the Central Office continue to plan on a child-by-child basis the most appropriate level of care that enables as many children as possible to remain in community settings. In addition, 37 therapeutic group homes opened since July 2005 are giving us more community options for children. These group homes play an important part in reducing the number of children in an out-of-state residential placement by 288 children in the 25-month period ending October 1, 2006 – a 41 percent reduction.

The Administrative Services Organization (ASO), which began operation in January 2006, is providing critical information about specific children and how well services are meeting their individual needs. The ASO also is generating important data about the need for specific services in specific areas of Connecticut that will assists us in serving children and building a stronger system overall.

Timely permanency continues to be an area of both great progress and great need. The goals for timely reunification have been met in five consecutive quarters, for timely adoption in four of seven quarters, and for timely transfer of guardianship in three of the last six quarters. Despite having missed the goal in the 3rd quarter for the timeliness of adoptions, we have substantially improved upon the 10.7 percent of timely adoptions recorded in early 2004. In comparison, more than 30 percent of adoptions were timely in five of the last seven quarters. Part of the improvement is a result of the Multi-disciplinary Assessment for Permanency (MAP) system in each area office, which has ensured that a legal consultation regarding permanency planning occurs early in every case. Despite the improvements in the timeliness of permanency, we recognize this area requires continued vigilance and more progress before we can say we are doing our best work for each and every child we serve.

CHALLENGES

The Department has continued its impressive inroads toward the goal of being the best child welfare organization possible. But part of being a top-notch agency is in knowing what needs improvement and what needs to be done to effect those improvements.

Treatment planning continues as a major focus of our efforts to improve. New methodology to measure this key aspect of our work has been established and case reviews indicate that much work remains to be accomplished in this area for us to optimally serve children and families. The Court Monitor's review of 34 cases shows that appropriate treatment plans were developed in 54 percent of cases compared to 10 percent in the 3rd quarter of 2004. We are pleased by this progress, although the Department has considerable progress to make in order to reach the goal.

Family conferencing remains a key strategy to improve treatment planning and our work overall. Multiple trainings statewide have been completed, and we are now engaged in extensive coaching in each area office to work with staff in identifying opportunities for this vitally important tool for engaging families as a key source of strength for children. Work with staff, supervisors and managers is ongoing to establish strategies to overcome barriers to family conferencing including family resistance, confidentiality, domestic violence and substance abuse issues, as well as ways to involve people who may not be family members but who have valuable connections to a child such as a coach or a teacher.

Efforts to establish family conferencing extend beyond DCF staff. Training in family conferencing is now underway with private service providers to facilitate a more complete partnership with families. Family conferencing also is an area of focus for new domestic violence consultants who are starting their work in every area office with DCF staff to assess families and plan services for families where domestic violence is prevalent.

The outcome for meeting children's needs also is the focus of much attention and energy at the Department. Similar to treatment plans, a new methodology and a recent case review indicates the need for considerably more work in this area. The Court Monitor review showed that needs was met in 62 percent of cases compared to 53 percent in the 1st quarter of 2004. Again we are a considerable distance from the goal.

While this overarching measure of our work and the equally foundational measure of treatment planning present special challenges, we are developing a significant number of initiatives that will impact these two outcomes as well as lead to even more generalized advances in how we do our work and the quality of services we offer children and families. Initiatives that will improve assessments, treatment plans, and case decisions include the following:

- **Structured Decision Making**: An evidence-based approach to delivering child welfare services that has proven valid and reliable. The decision to open a case for ongoing services is based upon an actuarial assessment of risk that is not individually predictive but assigns categories of risk based upon the family circumstances. Importantly this de-links case opening from an underlying

substantiation, distinguishes safety from risk, and has tools that focus workers on assessing family strengths as well as needs. This will produce greater consistency in our work and will help in targeting resources to where they can be most effective. Importantly, this consistency offers one way to mitigate the disproportionality seen in child welfare across the nation. All staff will be trained starting January and will be completed by April. Implementation will take place as the training rolls out through the offices.

- **Global Appraisal Of Individual Needs**: An evidence- based tool that was primarily designed for assessing treatment needs related to substance abuse. There are multiple versions that are essentially subsets of the full GAIN and are valid and reliable instruments. We have on staff in cooperation with the UCONN Health Center a nationally certified GAIN trainer who is in the process of training our investigation staff to employ the GAIN Short Scale as a part of our investigation protocol in all cases. Two offices, Bridgeport and New Britain, have been trained to date with a plan to complete all offices within the next 6 months. Our Intensive Family Preservation Providers are being trained in the administration of the GAIN Quick Scale and its follow up to implement as a part of their assessment services with the plan to complete that training by November of this year.

Initiatives that will improve how we deliver services include the following:

- **Differential Response**: A recognized "promising practice" in child welfare that has been piloted in the Hartford community for the past 2 years. This approach will be taken statewide next fiscal year and the remainder of this fiscal year is dedicated to planning, policy and implementation readiness. DRS utilizes a non-blaming, strength-based, assessment approach to engage families in identifying needs for the majority of accepted reports to the Hotline. There is no associated substantiation or placement of any adult on the Central Registry. The traditional forensic-based approach of a CPS investigation will be utilized only for those cases indicating serious injury or risk of immediate harm to a child. Available research indicates better child welfare outcomes with this approach with no attendant increase in instances of child maltreatment.

- **Intensive Safety Planning (ISP) At OTC Stage**: Designed to provide intensive services immediately upon removal so a child can be safety returned home before the 20 day contested OTC trial. DCF staff will utilize the SDM Safety Assessment to guide the removal decision. These services, which will be delivered as a specific program by our existing IFP providers, also will be informed by the GAIN Quick assessment tool. The SDM Safety Assessment tool will be re-administered as a guide in the decision regarding returning the child home. The model design is to provide the concrete services necessary to mitigate safety factors, and safety rather than risk will be the criteria for the return of the child. We anticipate this service will begin in most of the state by November and be available statewide by December.

Initiatives that will improve specific services offered to children and families include the following:

- **Building Stronger Families**: An evidence-based, integrated, in-home model for helping families with parents who need substance abuse treatment and children over the age of 7 who have suffered maltreatment and have mental health treatment needs. The Annie Casey Foundation supports this approach which currently is being piloted in New Britain and is a modification of the MST model. Services are being expanded to New Haven beginning in January 2007.

- **Intensive Home Based Services aka "Family-Based Recovery" Treatment (for substance abusing parent)**: Similar to Building Stronger Families except that the children are under age 2. Targets substance abuse of parents and maltreatment issues. This in-home substance abuse treatment program focuses on parenting skills and repairing parent/child attachment issues. In the process of awarding 4 contracts and 1 region (northwest) is being re-bid. Each of the five programs will serve 12 families at a time. Services are expected to begin in January.

- **Project SAFE Outreach And Engagement**: Now in Hartford and New Haven, this program will become a component of ISP (see above) starting November. Case managers work in the home to address substance abuse. High participation is anticipated in contrast to traditional Project SAFE outcomes.

- **Supportive Housing for Families**: The Supportive Housing for Recovering Families Program (SHRF) offers family support services and safe housing to families involved with DCF. The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF. Housing is funded through a combination of DCF funds, DSS Rental Assistance Program (RAP) certificates, and federal Section 8 Housing Vouchers. The program was recently expanded (July 06) to serve an additional 100 families increasing the total program capacity to 465 families.

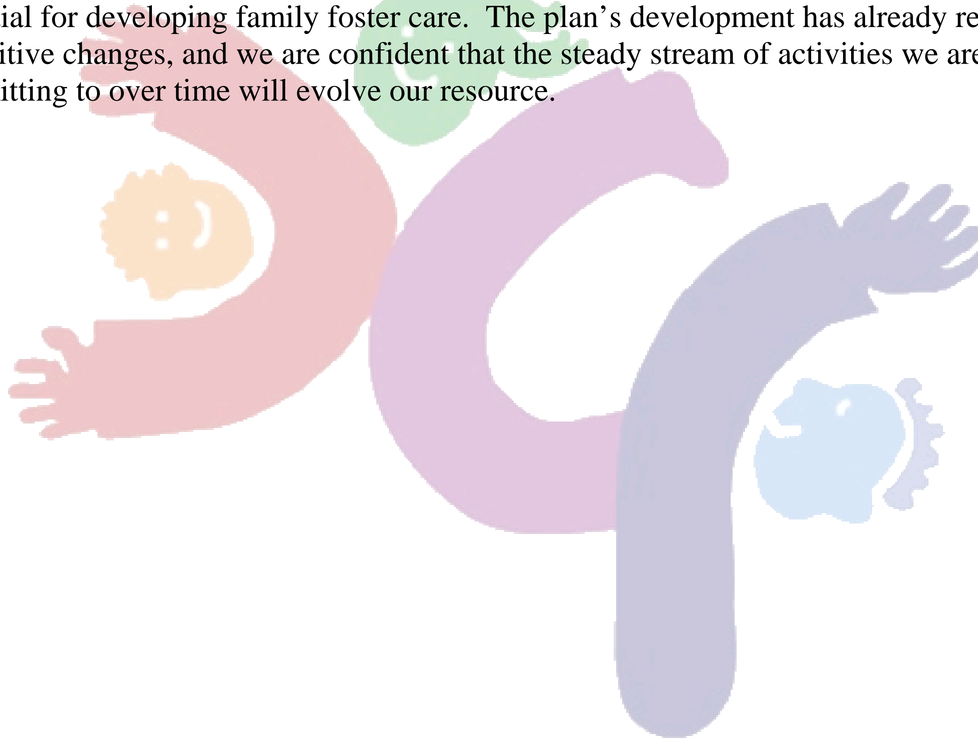
- **Short-Term Assessment Resource (STAR) Centers:** STAR Centers are now replacing the outdated shelter system across Connecticut. Instead of reliance on traditional shelters, which have struggled to meet the changing needs of children, "STAR" Centers around the state will offer treatment and support planning for a more effective course of care.

Taken together and in the context of all the other developments at the Department, we are equipping staff with an impressive array of tools to continue to make improvements in how we serve families and children and in the quality of services provided. At the same time, we recognize that more work remains to be accomplished and that challenges will always be present in the complex responsibilities that our staff face daily.

We must also be forthright about the inadequacy of our foster family placement resources. Nationally, as in Connecticut, recruiting new foster homes and retaining foster

homes presents a challenge. The Department continues work along several fronts to improve this resource. First, a significant infusion of management resources took place earlier this year. Five new program supervisors now focus exclusively on recruitment and retention in area offices around the state. Work continues to create quality standards for recruitment and retention activities across the 14 offices so that a uniform service delivery system and uniform levels of activity are established as well as enhanced data collection. In addition, the Department continues to research best practices around the nation as well as conduct research on attitudes among foster parents and the general public to improve recruitment and retention efforts.

Because this resource is essential to meeting the placement and service goals we are making progress towards as a Department, this area of work will continue to have the focused attention from top leadership in the Department and local efforts will be earnestly supported. And, as the Department enters its final stages of producing its multi-year master plan for foster care, a plan produced with considerable input from sources internal and external to DCF, we expect 2007 to be a pivotal year for realizing the state's potential for developing family foster care. The plan's development has already resulted in positive changes, and we are confident that the steady stream of activities we are committing to over time will evolve our resource.

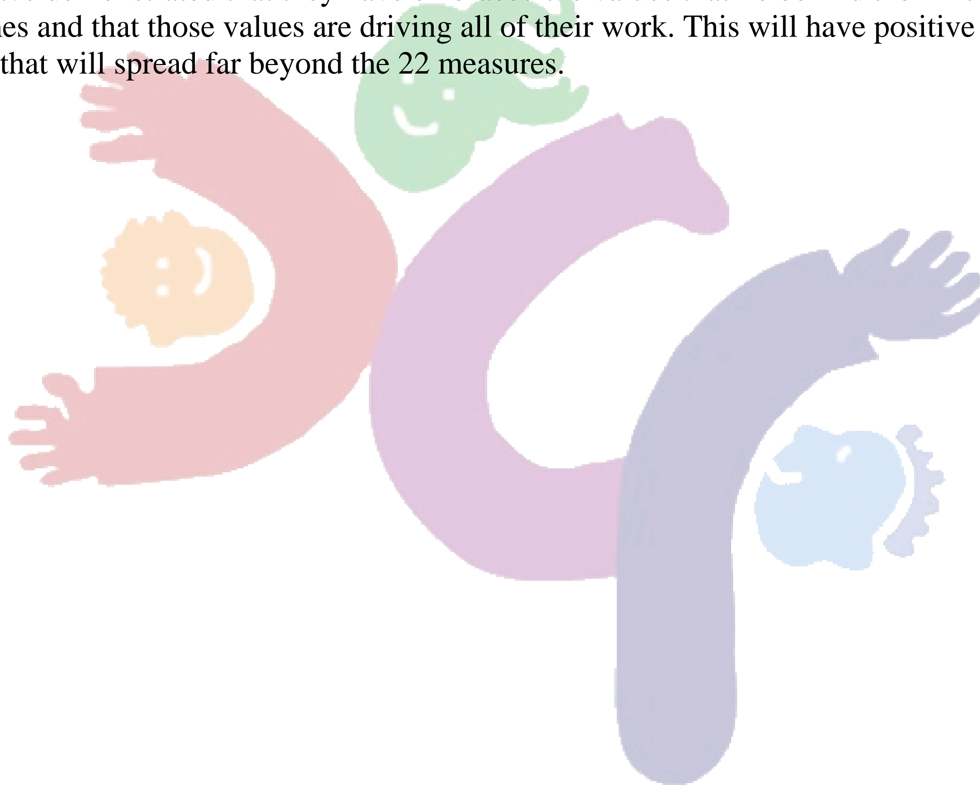


CONCLUSION

Department staff in the area offices and in the central office are taking great advantage of the opportunity presented by the Exit Plan to make strides in our work with children and families. Due to the complicated nature of this work, there will always be the need to continue improvements. There can be no saying "good enough" when working with vulnerable children and families in challenging situations.

At the same time, it is clear that staff already have instituted dramatic improvements in our work. None of the outcomes can be taken for granted, but many of the outcomes are firmly established in the routines of our practice. Challenges remain, but we are making important headway and are prepared to institute further structural reforms that promise further improvements.

Staff have demonstrated that they have embraced the values that lie behind the Exit Plan outcomes and that those values are driving all of their work. This will have positive effects that will spread far beyond the 22 measures.



3Q July 1-September 30, 2006 Exit Plan Report

Outcome Measure Overview

Measure	Measure	Baseline	1Q 2004	2Q 2004	3Q 2004	4Q 2004	1Q 2005	2Q 2005	3Q 2005	4Q 2005	1Q 2006	2Q 2006	3Q 2006
1: Investigation Commencement	>=90%	X	X	X	X	91.2%	92.5%	95.1%	96.2%	96.1%	96.2%	96.4%	98.7%
2: Investigation Completion	>=85%	73.7%	64.2%	68.8%	83.5%	91.7%	92.3%	92.3%	93.1%	94.2%	94.2%	93.1%	94.2%
3: Treatment Plans**	>=90%	X	X	X	10%	17%	X	X	X	X	X	X	54%
4: Search for Relatives*	>=85%	58%	93%	82%	44.6%	49.2%	65.1%	89.6%	89.9%	93.9%	93.1%	2/15/07*	5/15/07*
5: Repeat Maltreatment	<=7%	9.3%	9.4%	8.9%	9.4%	8.9%	8.2%	8.5%	9.1%	7.3%	6.3%	7.0%	7.9%
6: Maltreatment OOH Care	<=2%	1.2%	0.5%	0.8%	0.9%	0.6%	0.8%	0.7%	0.8%	0.6%	0.4%	0.7%	0.8%
7: Reunification*	>=60%	57.8%	X	X	X	X	X	X	64.2%	61%	66.4%	64.4%	62.5%
8: Adoption	>=32%	12.5%	10.7%	11.1%	29.6%	16.7%	33%	25.2%	34.4%	30.7%	40.8%	36.9%	27%
9: Transfer of Guardianship	>=70%	60.5%	62.8%	52.4%	64.6%	63.3%	64.0%	72.8%	64.3%*	72.4%	60.7%	63.1%	70.2%
10: Sibling Placement*	>=95%	57%	65%	53%	X	X	X	X	96%	94%	75%	77%	83%
11: Re-Entry	<=7%	6.9%	X	X	X	X	X	X	7.2%	7.6%	6.7%	7.5%	4.3%
12: Multiple Placements	>=85%	X	X	95.8%	95.2%	95.5%	96.2%	95.7%	95.8%	96%	96.2%	96.6%	95.6%
13: Foster Parent Training	100%	X	X	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
14: Placement Within Licensed Capacity	>=96%	94.9%	88.3%	92.0%	93.0%	95.7%	97%	95.9%	94.8%	96.2%	95.2%	94.5%	96.7%
15: Needs Met**	>=80%	X	53%	57%	53%	56%	X	X	X	X	X	X	62%
16: Worker-Child Visitation (OOH)*	>=85% 100%	Monthly Quarterly	72% 87%	86% 98%	73% 93%	81% 91%	77.9% 93.3%	86.7% 95.7%	83.3% 92.8%	85.6% 91.9%	86.8% 93.1%	86.5% 90.9%	92.5% 91.5%
17: Worker-Child Visitation (IH)*	>=85%	X	39%	40%	46%	33%	X	81.9%	78.3%	85.6%	86.2%	87.6%	85.7%
18: Caseload Standards+	100%	69.2%	73.1%	100%	100%	100%	100%	100%	99.8%	100%	100%	100%	100%
19: Residential Reduction	<=11%	13.5%	13.9%	14.3%	14.7%	13.9%	13.7%	12.6%	11.8%	11.6%	11.3%	10.8%	10.9%
20: Discharge Measures	>=85%	61%	74%	52%	93%	83%	X	X	96%	92%	85%	91%	100%
21: Discharge to DMHAS and DMR	100%	X	43%	64%	56%	60%	X	X	78%	70%	95%	97%	100%
22: MDE	>=85%	5.6%	19.0%	24.5%	48.9%	44.7%	55.4%	52.1%	54.6%	72.1%	91.1%	89.9%	86%

Results based on Case Reviews

OM	Comments
4	Link report posted for 3Q 2006 reflecting status of children entering care for the 1Q 2006 period. This is consistent with the Exit Plan measure definition. Refer to 1Q 2006 column.
7, 11	*LINK data via ROM report (as of 4Q 2005). Case Review no longer necessary.*
8, 9	*For 3Q 2006* ***Adoption results, 6 were n/a. A Case review was conducted to determine the status of these n/a cases**. **Adoption**: The following shows the results of the 6 case review: 0 met, 4 not met and 2 were non-applicable (1 was a duplicate and 1 adoption via probate for) and dropped from the totals.* ***Re-calculated** statewide results (total of 111adoptions): 27% (30) met and 73% (81) not met.* ***TOG results. A case review was conducted to determine the status of all 135 cases. TOG:** The following shows the results of the case review: 73 met and 31 not met and 31 not-applicable (all n/a were reunify back to parent/legal guardian).* ***Re-calculated** statewide results show (total of 104 transfers of guardianship): TOG -70.2% met the goal and 29.8 % not met.*
10	*ROM with full supplemental case review.*
16, 17	*As of 3Q 2005 the Department will include the one visit per quarter results for OM 16. This method reports **all** children in care who had 1 (one) visit during the quarter period. The LINK system is unable to determine if the visits were made by the assigned social worker as indicated in the Exit Plan.*

Treatment Plans**

** Conducted by the Court Monitor's Office.

2006

1Q N/A
2Q N/A
3Q 54% (refer to Court Monitor's Report for results of their case review)

2006
In addition, two (2) additional areas were evaluated: Treatment plan must be written and treatment conference conducted in the family's primary language and treatment plans developed in conjunction with parents/child/service providers (for example, treatment plan modifications as a result of input from the ACR).

1Q N/A
2Q N/A
3Q 100% (refer to Court Monitor's Report for results of their case review)

Caseload Standards +

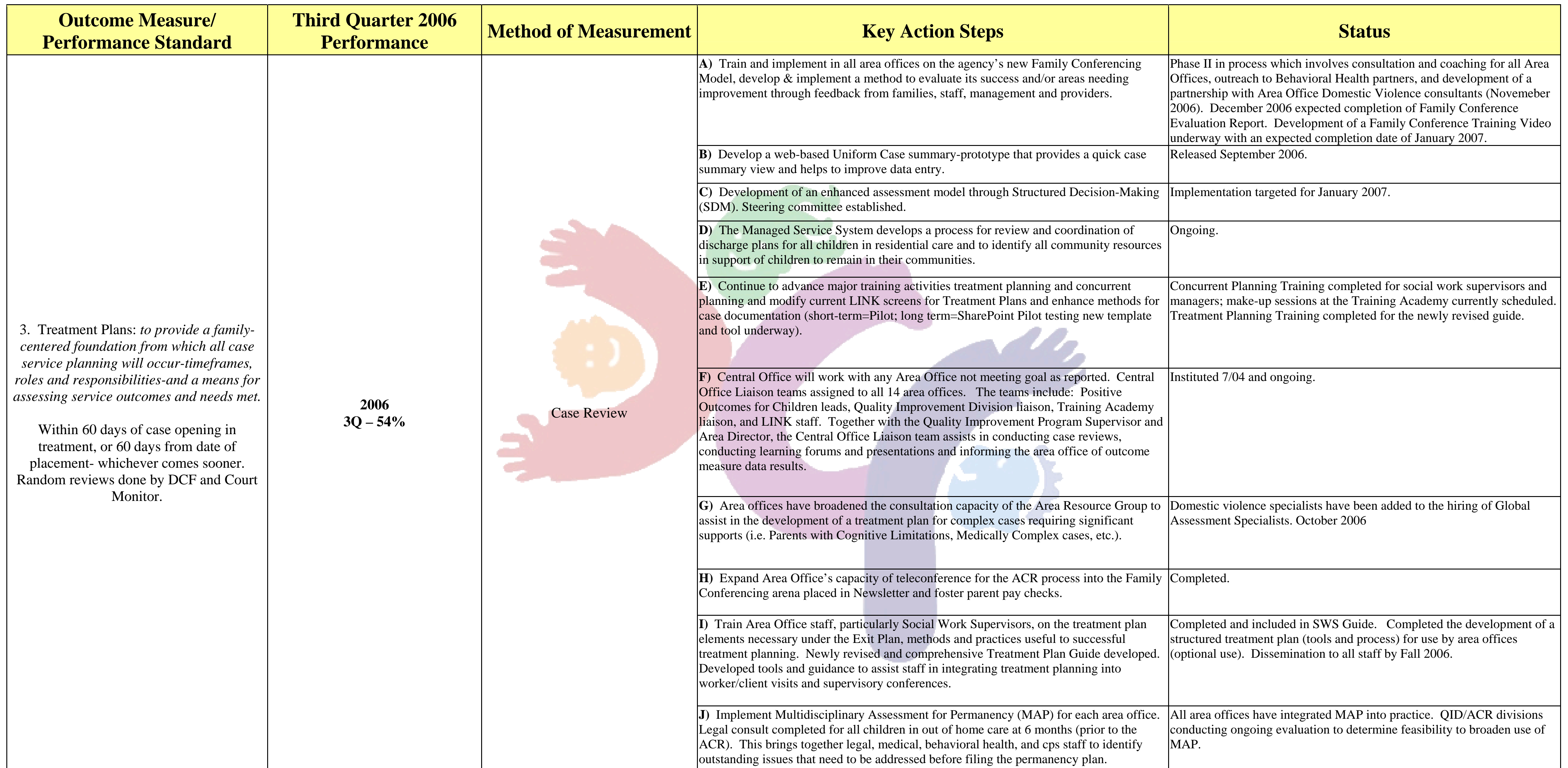
2006

1Q As of May 15, 2006 the Department met the 100% compliance mark. The sixty (60) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

2Q As of August 15, 2006 the Department met the 100% compliance mark. The thirty (30) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

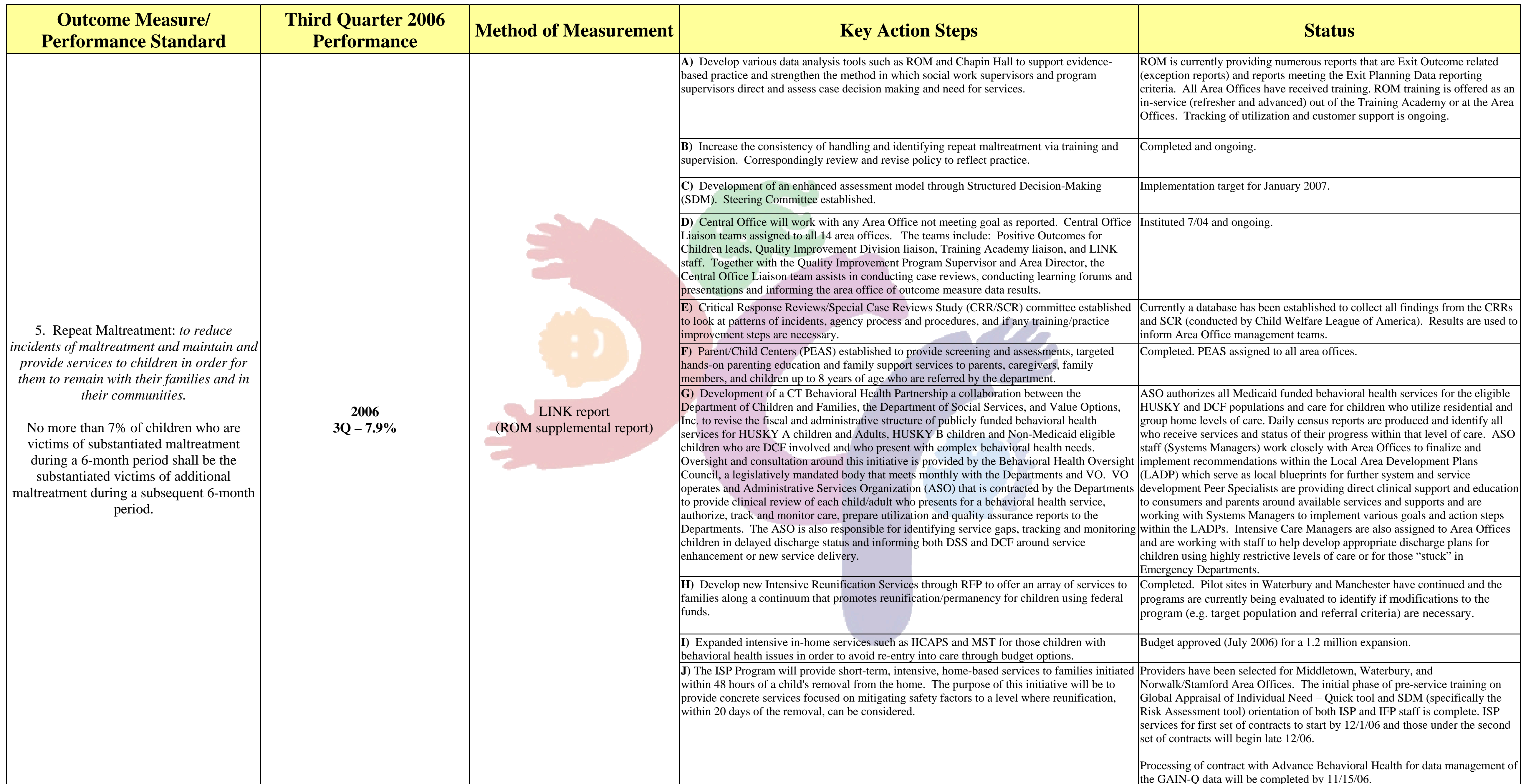
3Q As of September 30, 2006 the Department met the 100% compliance mark. The forty (40) cases over 100% caseload utilization meet the exception criteria (cases over 100% and not over for 30 days or more).

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
1. Commencement of Investigation: *to assure that assessments of safety can quickly be determined and increases collaborative interviewing and intervention.* 90% of all reports must be commenced same calendar day, 24 hours or 72 hours depending on referral code.	**2006** **3Q – 98.7%**	LINK report (ROM supplemental report)	**A)** Developed LINK capacity to document and measure commencement time and modifications to commencement time. Provided corresponding LINK training to staff.	Completed
			B) Revision of policy #34-3-3 "Conducting the Investigation"- To direct that the Social Work Supervisor can approve modification of commencement times. Previously, Program Supervisor approval was required and was inefficient.	Completed.
			C) Area Offices use LINK data reports to assess staffing levels in investigations and take any supervisory or practice improvement steps necessary to ensure performance goals.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
2. Completion of Investigation: *to assure that case assessment and disposition is handled in a timely manner.* 85% of all reports shall have their investigations completed within 45 calendar days of acceptance.	**2006** **3Q – 94.2%**	LINK report (ROM supplemental report)	**A)** Implement a quality review process in each Area Office that serves as a tickler system at 28, 35, and 40 days and calls for any corrective action plans.	Completed.
			B) Developed a quality review process for the Special Investigations Unit through Hotline.	Completed.
			C) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Developed standards for the release of information that assists with the sharing of information between DCF and community providers and/or other state agencies.	Completed.
			F) The department proposed legislation requesting a change in the statutory requirement of completing investigations within 30 days. This request change extended the statutory requirement to 45 days to comport with the Exit Plan.	PASSED: Effective October 1, 2005. Staff informed via all staff Commissioner e-mail and via the newly developed SWS Guide to Exit Plan and Practice Points.



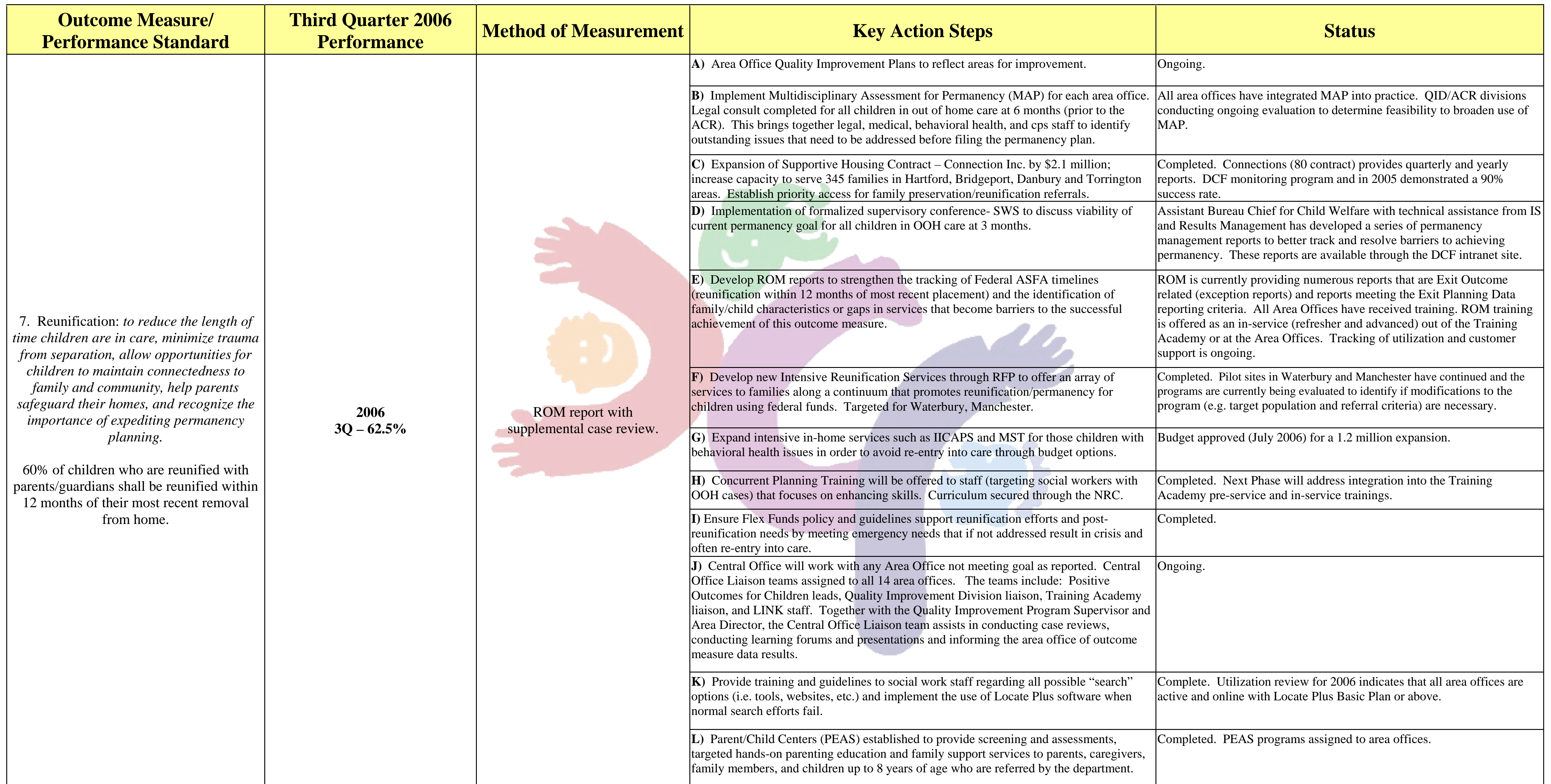
Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
3. Treatment Plans: *to provide a family-centered foundation from which all case service planning will occur-timeframes, roles and responsibilities-and a means for assessing service outcomes and needs met.* Within 60 days of case opening in treatment, or 60 days from date of placement- whichever comes sooner. Random reviews done by DCF and Court Monitor.	**2006** **3Q – 54%**	Case Review	**A)** Train and implement in all area offices on the agency's new Family Conferencing Model, develop & implement a method to evaluate its success and/or areas needing improvement through feedback from families, staff, management and providers.	Phase II in process which involves consultation and coaching for all Area Offices, outreach to Behavioral Health partners, and development of a partnership with Area Office Domestic Violence consultants (Novemeber 2006). December 2006 expected completion of Family Conference Evaluation Report. Development of a Family Conference Training Video underway with an expected completion date of January 2007.
			B) Develop a web-based Uniform Case summary-prototype that provides a quick case summary view and helps to improve data entry.	Released September 2006.
			C) Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering committee established.	Implementation targeted for January 2007.
			D) The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing.
			E) Continue to advance major training activities treatment planning and concurrent planning and modify current LINK screens for Treatment Plans and enhance methods for case documentation (short-term=Pilot; long term=SharePoint Pilot testing new template and tool underway).	Concurrent Planning Training completed for social work supervisors and managers; make-up sessions at the Training Academy currently scheduled. Treatment Planning Training completed for the newly revised guide.
			F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			G) Area offices have broadened the consultation capacity of the Area Resource Group to assist in the development of a treatment plan for complex cases requiring significant supports (i.e. Parents with Cognitive Limitations, Medically Complex cases, etc.).	Domestic violence specialists have been added to the hiring of Global Assessment Specialists. October 2006
			H) Expand Area Office's capacity of teleconference for the ACR process into the Family Conferencing arena placed in Newsletter and foster parent pay checks.	Completed.
			I) Train Area Office staff, particularly Social Work Supervisors, on the treatment plan elements necessary under the Exit Plan, methods and practices useful to successful treatment planning. Newly revised and comprehensive Treatment Plan Guide developed. Developed tools and guidance to assist staff in integrating treatment planning into worker/client visits and supervisory conferences.	Completed and included in SWS Guide. Completed the development of a structured treatment plan (tools and process) for use by area offices (optional use). Dissemination to all staff by Fall 2006.
			J) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
4. Search for Relatives: *to increase the availability of supports for children consistent with the goal of keeping them within their community and in maintaining lifelong family ties.* DCF shall conduct searches for relatives, extended or informal networks, friends, family, former foster parents or other significant persons known to the child. Must be documented in LINK.	**2006** **3Q – 93.1%** Data reflects 2006 Qtr 1 due to a 6-month lag	LINK report (ROM supplemental report)	**A)** Implemented the Placement Resource Search window in one central place in LINK for accurate and easily accessible documentation of placement resource search efforts and institute tickler system at fifth month to identify those cases that do not have a window.	Completed. Exception "tracking" report posted on intranet and created for use by the area office staff.
			B) Use family conferencing model to assist in the identification of appropriate relative resources early on in the life of the case.	Ongoing.
			C) Revise Search – Requests for Identifying Information policy (41-40-8) and Affidavit	Awaiting approval.
			D) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			E) Started Casey Family Programs Supporting Kinship Care Collaborative in the Bridgeport area office.	Completed.
			F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			G) Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.



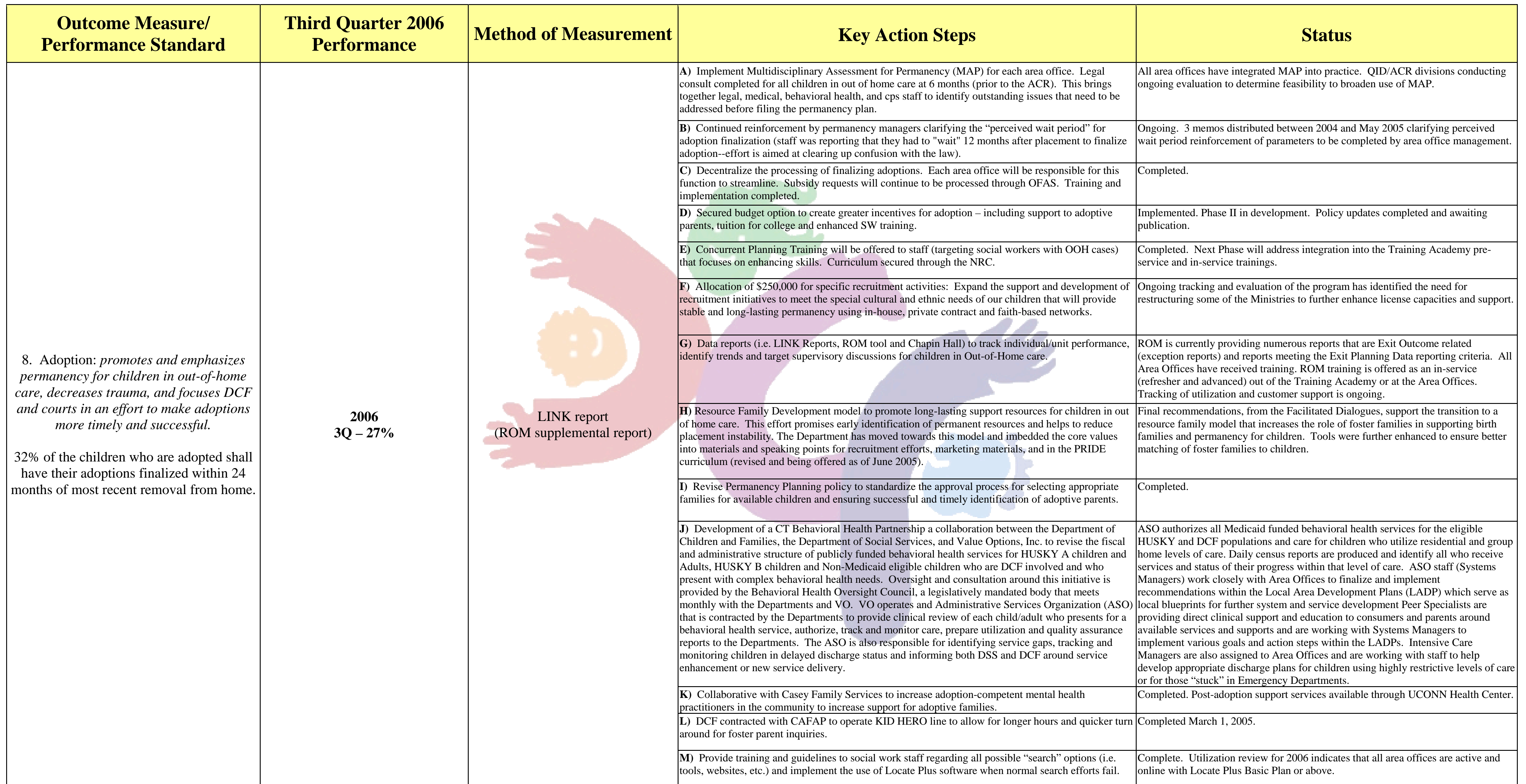
Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
5. Repeat Maltreatment: *to reduce incidents of maltreatment and maintain and provide services to children in order for them to remain with their families and in their communities.* No more than 7% of children who are victims of substantiated maltreatment during a 6-month period shall be the substantiated victims of additional maltreatment during a subsequent 6-month period.	**2006 3Q – 7.9%**	LINK report (ROM supplemental report)	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing numerous reports that are Exit Outcome related (exception reports) and reports meeting the Exit Planning Data reporting criteria. All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.
			B) Increase the consistency of handling and identifying repeat maltreatment via training and supervision. Correspondingly review and revise policy to reflect practice.	Completed and ongoing.
			C) Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering Committee established.	Implementation target for January 2007.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			E) Critical Response Reviews/Special Case Reviews Study (CRR/SCR) committee established to look at patterns of incidents, agency process and procedures, and if any training/practice improvement steps are necessary.	Currently a database has been established to collect all findings from the CRRs and SCR (conducted by Child Welfare League of America). Results are used to inform Area Office management teams.
			F) Parent/Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS assigned to all area offices.
			G) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			H) Develop new Intensive Reunification Services through RFP to offer an array of services to families along a continuum that promotes reunification/permanency for children using federal funds.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			I) Expanded intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion.
			J) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	Providers have been selected for Middletown, Waterbury, and Norwalk/Stamford Area Offices. The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. ISP services for first set of contracts to start by 12/1/06 and those under the second set of contracts will begin late 12/06. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
6. Maltreatment in care - Out-of-home: *to assure children's safety while in out-of-home care, improve placement stability, and reduce additional trauma.* No more than 2% of children in out of home care shall be the victims of substantiated maltreatment by substitute caretaker.	**2006** **3Q – 0.8%**	LINK report (ROM supplemental report)	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing numerous reports that are Exit Outcome related (exception reports) and reports meeting the Exit Planning Data reporting criteria. All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.
			B) Moved Special Investigations management from Hotline to a direct report under Bureau Chief for Child Welfare. In addition, to provide consistency with investigating and tracking of foster care maltreatment, reports of abuse/neglect concerning foster families have been moved to the Special Investigation Unit and are now centralized.	Completed.
			C) Develop and implement a corrective action plan protocol for all regulatory violations and all out-of-home substantiations. Incorporate any corrective action plans into Foster Family Support Plan.	Completed.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.



Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
7. Reunification: *to reduce the length of time children are in care, minimize trauma from separation, allow opportunities for children to maintain connectedness to family and community, help parents safeguard their homes, and recognize the importance of expediting permanency planning.* 60% of children who are reunified with parents/guardians shall be reunified within 12 months of their most recent removal from home.	**2006** **3Q – 62.5%**	ROM report with supplemental case review.	**A)** Area Office Quality Improvement Plans to reflect areas for improvement.	Ongoing.
			B) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			C) Expansion of Supportive Housing Contract – Connection Inc. by $2.1 million; increase capacity to serve 345 families in Hartford, Bridgeport, Danbury and Torrington areas. Establish priority access for family preservation/reunification referrals.	Completed. Connections (80 contract) provides quarterly and yearly reports. DCF monitoring program and in 2005 demonstrated a 90% success rate.
			D) Implementation of formalized supervisory conference- SWS to discuss viability of current permanency goal for all children in OOH care at 3 months.	Assistant Bureau Chief for Child Welfare with technical assistance from IS and Results Management has developed a series of permanency management reports to better track and resolve barriers to achieving permanency. These reports are available through the DCF intranet site.
			E) Develop ROM reports to strengthen the tracking of Federal ASFA timelines (reunification within 12 months of most recent placement) and the identification of family/child characteristics or gaps in services that become barriers to the successful achievement of this outcome measure.	ROM is currently providing numerous reports that are Exit Outcome related (exception reports) and reports meeting the Exit Planning Data reporting criteria. All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.
			F) Develop new Intensive Reunification Services through RFP to offer an array of services to families along a continuum that promotes reunification/permanency for children using federal funds. Targeted for Waterbury, Manchester.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			G) Expand intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion.
			H) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			I) Ensure Flex Funds policy and guidelines support reunification efforts and post-reunification needs by meeting emergency needs that if not addressed result in crisis and often re-entry into care.	Completed.
			J) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			K) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			L) Parent/Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS programs assigned to area offices.

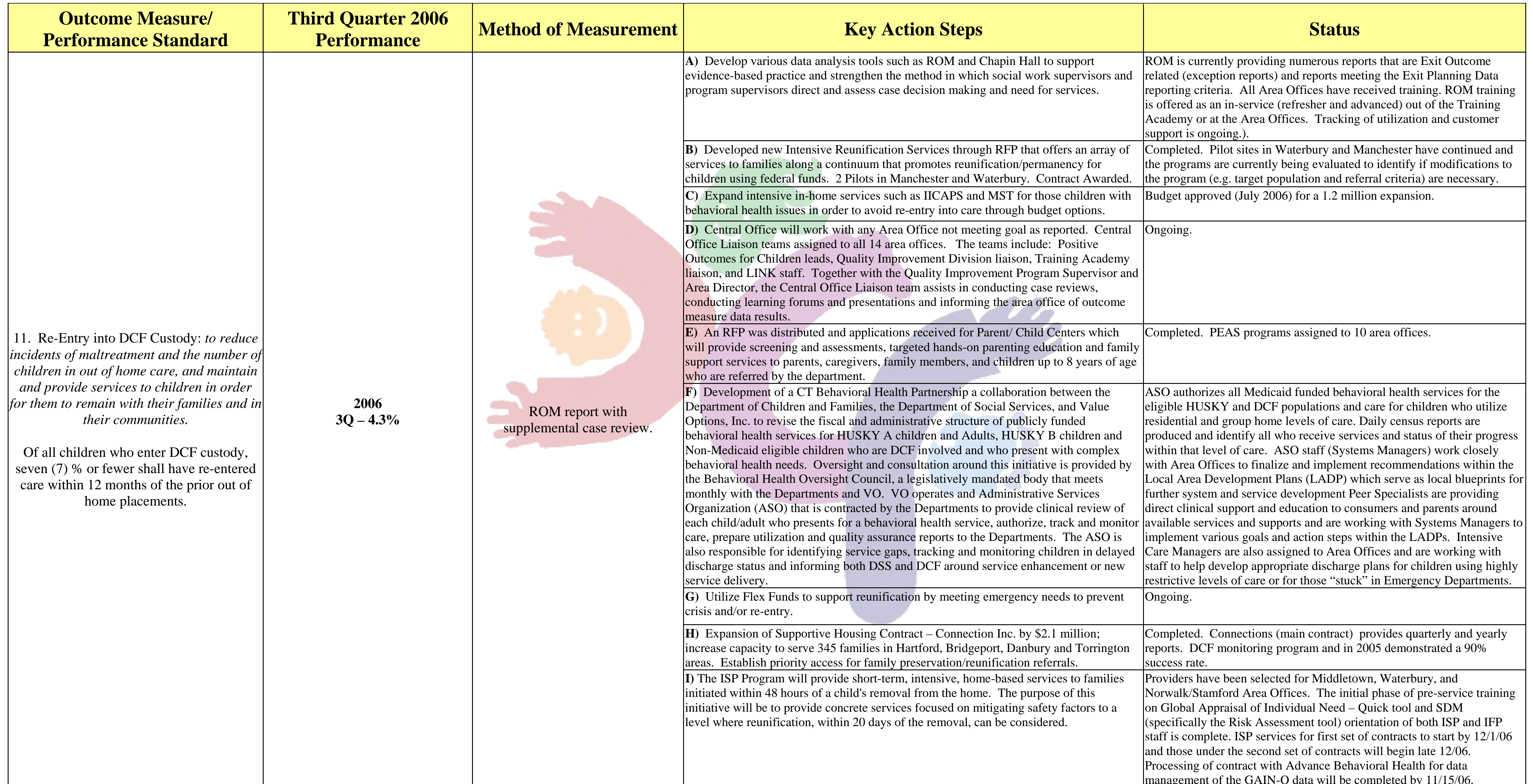
Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
			M) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			N) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	Providers have been selected for Middletown, Waterbury, and Norwalk/Stamford Area Offices. The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. ISP services for first set of contracts to start by 12/1/06 and those under the second set of contracts will begin late 12/06. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.



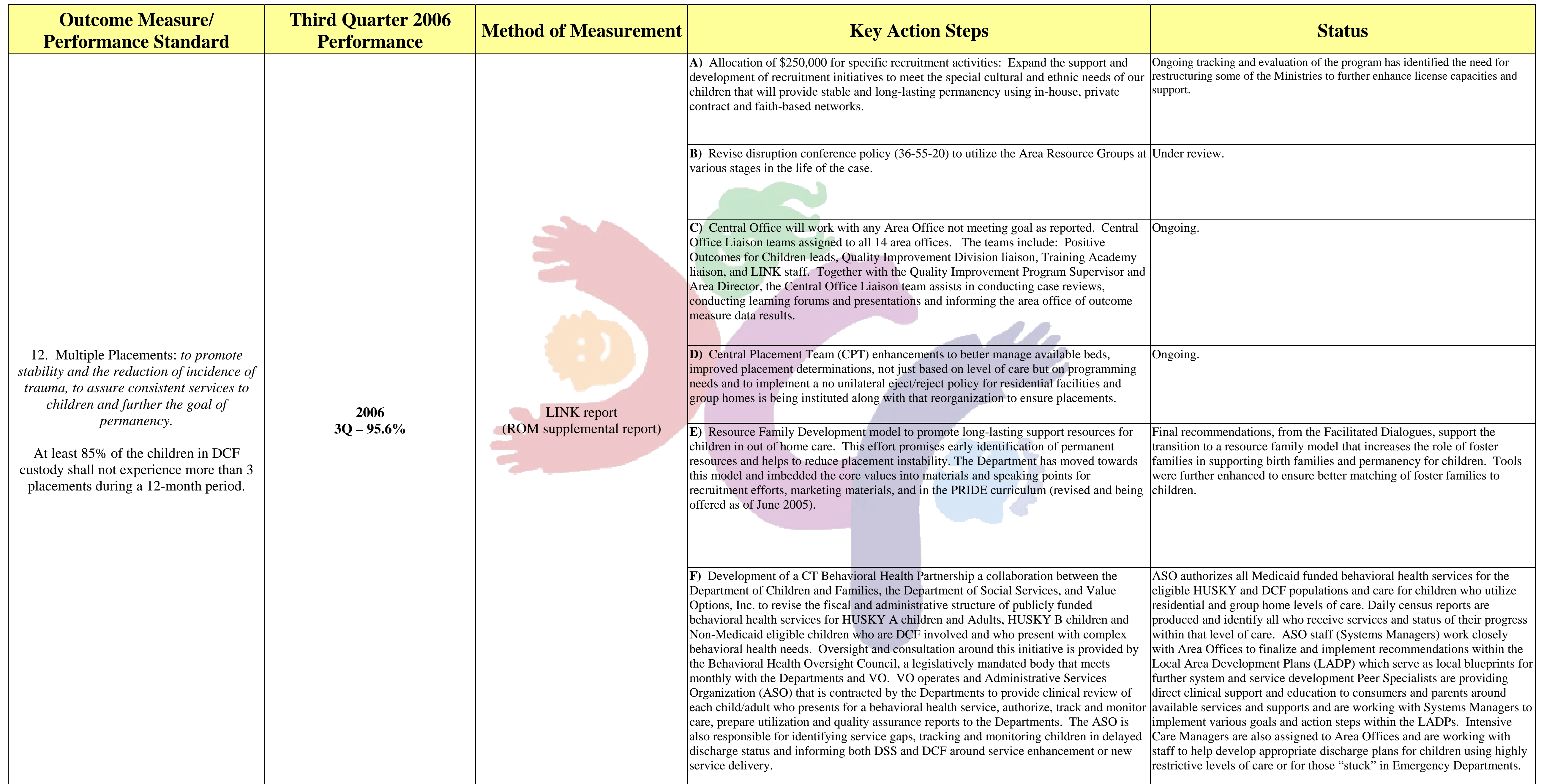
Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
8. Adoption: *promotes and emphasizes permanency for children in out-of-home care, decreases trauma, and focuses DCF and courts in an effort to make adoptions more timely and successful.* 32% of the children who are adopted shall have their adoptions finalized within 24 months of most recent removal from home.	**2006** **3Q – 27%**	LINK report (ROM supplemental report)	**A)** Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			B) Continued reinforcement by permanency managers clarifying the "perceived wait period" for adoption finalization (staff was reporting that they had to "wait" 12 months after placement to finalize adoption--effort is aimed at clearing up confusion with the law).	Ongoing. 3 memos distributed between 2004 and May 2005 clarifying perceived wait period reinforcement of parameters to be completed by area office management.
			C) Decentralize the processing of finalizing adoptions. Each area office will be responsible for this function to streamline. Subsidy requests will continue to be processed through OFAS. Training and implementation completed.	Completed.
			D) Secured budget option to create greater incentives for adoption – including support to adoptive parents, tuition for college and enhanced SW training.	Implemented. Phase II in development. Policy updates completed and awaiting publication.
			E) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			F) Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support.
			G) Data reports (i.e. LINK Reports, ROM tool and Chapin Hall) to track individual/unit performance, identify trends and target supervisory discussions for children in Out-of-Home care.	ROM is currently providing numerous reports that are Exit Outcome related (exception reports) and reports meeting the Exit Planning Data reporting criteria. All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.
			H) Resource Family Development model to promote long-lasting support resources for children in out of home care. This effort promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.
			I) Revise Permanency Planning policy to standardize the approval process for selecting appropriate families for available children and ensuring successful and timely identification of adoptive parents.	Completed.
			J) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			K) Collaborative with Casey Family Services to increase adoption-competent mental health practitioners in the community to increase support for adoptive families.	Completed. Post-adoption support services available through UCONN Health Center.
			L) DCF contracted with CAFAP to operate KID HERO line to allow for longer hours and quicker turn around for foster parent inquiries.	Completed March 1, 2005.
			M) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
9. Transfer of Guardianship: *promotes and emphasizes permanency for children in out-of-home care, decreases trauma, and allows children to maintain connection with family.* 70% of all children, whose custody is legally transferred, shall have the guardianship transferred within 24 months of the child's most recent removal from home.	**2006** **3Q – 70.2%**	LINK report (ROM supplemental report)	**A)** Area Office Quality Improvement Plans to reflect areas for improvement and progress.	Ongoing.
			B) Implement a Licensing Review Team for consideration of waivers for relative caregivers who have been denied licensure due to substantiated CPS history and/or criminal history.	Completed.
			C) Revised subsidized guardianship policy (41-50-1 through 41-50-14) to reflect current practice and ASFA timeframes.	Completed.
			D) Revise Permanency Planning Team policy (48-14-6 through 48-14-6.5) to reflect the approval process for subsidized guardianships.	Finalized and distributed policy.
			E) Concurrent Planning Training will be offered to staff (targeting social workers with OOH cases) that focuses on enhancing skills. Curriculum secured through the NRC.	Completed. Next Phase will address integration into the Training Academy pre-service and in-service trainings.
			F) Legislation passed that shortened the timeframe for relative foster care eligibility into the subsidized guardianship program to a minimum of 6 months (from 12 months) in placement.	Completed.
			G) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Instituted 7/04 and ongoing.
			H) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			I) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			J) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
10. Sibling Placement: *maintains life's longest lasting relationship, increases family connections, and decreases trauma.* 95% of siblings entering out of home placement shall be placed together unless there are documented reasons for separate placements.	**2006** **3Q – 83%** Data reflects 2006 Qtr 1 due to 6 months lag	LINK report (ROM supplemental report)	**A)** Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our sibling groups that will provide permanency using in-house, private contract and faith-based networks. Enhance contract support for specialized foster care recruitment.	Ongoing.
			B) Informed staff to use the definition and intent of outcome #10, what is used to define "sibling," and what is an acceptable therapeutic reason to not place siblings together.	Completed.
			C) Utilization of Flex Funds policy and guidelines support sibling placement efforts by meeting emergency needs.	Ongoing.
			D) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			E) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			F) Develop a Sibling Visitation Project to support monthly visits for separated, sibling groups in out of home care.	Area Offices have continued to utilize the $200,000 funds to support sibling visitation efforts and new funding for the upcoming fiscal year has been available.



Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
11. Re-Entry into DCF Custody: *to reduce incidents of maltreatment and the number of children in out of home care, and maintain and provide services to children in order for them to remain with their families and in their communities.* Of all children who enter DCF custody, seven (7) % or fewer shall have re-entered care within 12 months of the prior out of home placements.	**2006** **3Q – 4.3%**	ROM report with supplemental case review.	**A)** Develop various data analysis tools such as ROM and Chapin Hall to support evidence-based practice and strengthen the method in which social work supervisors and program supervisors direct and assess case decision making and need for services.	ROM is currently providing numerous reports that are Exit Outcome related (exception reports) and reports meeting the Exit Planning Data reporting criteria. All Area Offices have received training. ROM training is offered as an in-service (refresher and advanced) out of the Training Academy or at the Area Offices. Tracking of utilization and customer support is ongoing.).
			B) Developed new Intensive Reunification Services through RFP that offers an array of services to families along a continuum that promotes reunification/permanency for children using federal funds. 2 Pilots in Manchester and Waterbury. Contract Awarded.	Completed. Pilot sites in Waterbury and Manchester have continued and the programs are currently being evaluated to identify if modifications to the program (e.g. target population and referral criteria) are necessary.
			C) Expand intensive in-home services such as IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care through budget options.	Budget approved (July 2006) for a 1.2 million expansion.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) An RFP was distributed and applications received for Parent/ Child Centers which will provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS programs assigned to 10 area offices.
			F) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those “stuck” in Emergency Departments.
			G) Utilize Flex Funds to support reunification by meeting emergency needs to prevent crisis and/or re-entry.	Ongoing.
			H) Expansion of Supportive Housing Contract – Connection Inc. by $2.1 million; increase capacity to serve 345 families in Hartford, Bridgeport, Danbury and Torrington areas. Establish priority access for family preservation/reunification referrals.	Completed. Connections (main contract) provides quarterly and yearly reports. DCF monitoring program and in 2005 demonstrated a 90% success rate.
			I) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	Providers have been selected for Middletown, Waterbury, and Norwalk/Stamford Area Offices. The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. ISP services for first set of contracts to start by 12/1/06 and those under the second set of contracts will begin late 12/06. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.



Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
12. Multiple Placements: *to promote stability and the reduction of incidence of trauma, to assure consistent services to children and further the goal of permanency.* At least 85% of the children in DCF custody shall not experience more than 3 placements during a 12-month period.	**2006** **3Q – 95.6%**	LINK report (ROM supplemental report)	**A)** Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support.
			B) Revise disruption conference policy (36-55-20) to utilize the Area Resource Groups at various stages in the life of the case.	Under review.
			C) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			D) Central Placement Team (CPT) enhancements to better manage available beds, improved placement determinations, not just based on level of care but on programming needs and to implement a no unilateral eject/reject policy for residential facilities and group homes is being instituted along with that reorganization to ensure placements.	Ongoing.
			E) Resource Family Development model to promote long-lasting support resources for children in out of home care. This effort promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.
			F) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
13. Foster Parent Training: *to increase the capacity of foster families to meet the needs of our children and to assure a sense of partnership and support.* Foster parents shall be offered 45 hours post licensing training within 18 months of initial licensure and at least 9 hours each subsequent year. Does not apply to relative, special study or independently licensed foster parents- they require 8 hours pre-service.	**2006** **3Q – 100%**	CAFAP Report	**A)** Convened foster parent advisory group to evaluate pre and post licensing training. To be convened by POC lead twice a year to evaluate quarterly planning efforts by CAFAP.	Ongoing.
			B) Develop alternative methods for training (i.e. online), increase training for Spanish-speaking providers, use seminars or conferences in the community such as Board of Education, hospitals, & partner agencies. Sponsored events.	Ongoing. Current emphasis on improving communication materials and classes for Spanish speaking providers. CAFAP in process of translating flyers in Spanish.
			C) Developed training modifications based on CAFAP report and findings. In service was held on 2/21/05 for nine new trainees in areas where curriculum is needed for further development.	Ongoing.
			D) CAFAP will submit training certification data to Assistant Bureau Chief of Child Welfare for enhanced tracking of post-licensing training. This will ensure licensing completion.	Ongoing.
			E) DCF to develop other training avenue through the Training Academy and other sponsored training. CAFAP to promote through their areas of communication.	Ongoing. DCF training academy catalog classes now open to foster parent participation.
14. Placement within Licensed Capacity: *to reduce the level of stress that can result in disruption and maltreatment, to maintain stability of placement and reduce trauma, and to focus DCF in its effort to recruit foster families.* At least 96% of children placed in foster homes shall operate within their licensed capacity, except when necessary to accommodate siblings.	**2006** **3Q – 96.7%**	LINK report (ROM supplemental report)	**A)** Use family conferencing model to assist in the identification of appropriate relative resources early on in the life of the case.	Ongoing.
			B) Allocation of $250,000 for specific recruitment activities: Expand the support and development of recruitment initiatives to meet the special cultural and ethnic needs of our children that will provide stable and long-lasting permanency using in-house, private contract and faith-based networks.	Ongoing tracking and evaluation of the program has identified the need for restructuring some of the Ministries to further enhance license capacities and support.
			C) When there is a need to approve overcapacity placement the Department shall document the need and develop a support plan in LINK narrative for the home to assure stability.	Completed.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Provide training and guidelines to social work staff regarding all possible "search" options (i.e. tools, websites, etc.) and implement the use of Locate Plus software when normal search efforts fail.	Complete. Utilization review for 2006 indicates that all area offices are active and online with Locate Plus Basic Plan or above.
			F) Resource Family Development model to promote long-lasting support resources for children in out of home care. This strategy promises early identification of permanent resources and helps to reduce placement instability. The Department has moved towards this model and imbedded the core values into materials and speaking points for recruitment efforts, marketing materials, and in the PRIDE curriculum (revised and being offered as of June 2005).	Final recommendations, from the Facilitated Dialogues, support the transition to a resource family model that increases the role of foster families in supporting birth families and permanency for children. Tools were further enhanced to ensure better matching of foster families to children.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
15. Needs Met: *to prioritize service needs, identify service gaps, eliminate service redundancy, and facilitate access in order to assure a family's physical and emotional well-being and ultimately build their capacity as a family.* At least 80% of families' and children's medical, dental, mental health and other service needs as specified in the treatment plan must be documented in LINK.	**2006** **3Q – 62%**	Qualitative case reviews will be used to measure this outcome for all Quarter reports. No LINK reports available.	**A)** Development of an enhanced assessment model through Structured Decision-Making (SDM). Steering Committee established.	Implementation targeted for January 2007.
			B) The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing in all area offices.
			C) Budget option approved to expand Intensive In-Home to offer an array of services to families along a continuum that promotes reunification/permanency for children and expand intensive in-home services such as, IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care.	Budget approved (July 2006) for a 1.2 million expansion.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Pursuant to federal law, DCF has established a referral protocol for all children under the age of 3 involved in a substantiated CPS case to Birth to Three for evaluation.	Completed.
			F) Bi-monthly meetings with the MHPDs of ARG to involve, when appropriate, updates about new, expanded and available health care services to improve awareness and expedite access. Area offices have broadened the consultation capacity of the Area Resource Group to assist in the development of a treatment plan for complex cases requiring significant supports (i.e. Parents with Cognitive Limitations, Medically Complex cases, etc.).	Complete hiring of psychologists.
			G) Expand new diagnostic facilities by 5-14 to eliminate wait-lists and transportation barriers for children.	All up and running.
			H) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			I) Parent/ Child Centers (PEAS) established to provide screening and assessments, targeted hands-on parenting education and family support services to parents, caregivers, family members, and children up to 8 years of age who are referred by the department.	Completed. PEAS assigned to all area offices.
			J) Implement a no unilateral eject/reject policy for residential facilities and group homes	Completed.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
			K) Central Placement Team (CPT) enhancements to better manage available beds, improved placement determinations, not just based on level of care but on programming needs and to implement a no unilateral eject/reject policy for residential facilities and group homes is being instituted along with that reorganization to ensure placements.	Ongoing.
			L) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	Providers have been selected for Middletown, Waterbury, and Norwalk/Stamford Area Offices. The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. ISP services for first set of contracts to start by 12/1/06 and those under the second set of contracts will begin late 12/06. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.
			M) Implement Multidisciplinary Assessment for Permanency (MAP) for each area office. Legal consult completed for all children in out of home care at 6 months (prior to the ACR). This brings together legal, medical, behavioral health, and cps staff to identify outstanding issues that need to be addressed before filing the permanency plan.	All area offices have integrated MAP into practice. QID/ACR divisions conducting ongoing evaluation to determine feasibility to broaden use of MAP.
			N) *Shelter Re-Design* STAR Centers are now replacing the shelter system across Connecticut. "STAR" Centers will offer treatment and support planning for a more effective course of care.	In process.

<table>
<tr><th>Outcome Measure/ Performance Standard</th><th>Third Quarter 2006 Performance</th><th>Method of Measurement</th><th>Key Action Steps</th><th>Status</th></tr>
<tr><td rowspan="6">16, 17. Worker-Child Visitation- Out of Home/Worker-Child Visitation- In Home: to establish an ongoing means to assess family status, including safety issues, and monitoring progress towards treatment plan goals.

#16: DCF shall visit at least 85% of children in out of home care at least once a month except for probate, interstate and voluntary.

#17: DCF shall visit at least 85% of all in-home family cases at least twice a month, except for probate, interstate or voluntary cases.</td><td rowspan="6">2006
3Q

#16:
Monthly: 92.5%
Quarterly: 91.5 %

#17:
Quarterly: 85.7%</td><td rowspan="6">LINK report
(ROM supplemental report)</td><td>A) Agreement reached with Court Monitor to allow for private agency SW's visits to count and for information concerning these visits to be documented in LINK. Clarify DCF representation and include visits made by FASU (Out-of-Home). Per Monitor Agreement, define the role of the ICPC and other "DCF representatives" in achieving visitation requirements.</td><td>Completed.</td></tr>
<tr><td>B) Assignment of 5 positions to be posted to out-of-state residential facilities as the responsible party for visiting all the DCF youth in the assigned residential facilities. Role announced in March newsletter to staff.</td><td>Completed.</td></tr>
<tr><td>C) To assure greater success for social workers in meeting the visitation requirements, achievement of caseload standards occurred August 15, 2004 and the receipt of 100 new state vehicles was acquired by November 1, 2004.</td><td>Completed.</td></tr>
<tr><td>D) Re-establish the use of face-to-face contact narratives via a LINK build in December. "Attempted face to face no contact" via LINK build - April 2005.</td><td>Completed.</td></tr>
<tr><td>E) Area Office Quality Improvement Plans to reflect areas for improvement.</td><td>Ongoing.</td></tr>
<tr><td>F) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.</td><td>Ongoing.</td></tr>
<tr><td rowspan="4">18. Caseload Standards: to increase the quality of our interventions and supports to children and their families.

Current standards remain - 100%.</td><td rowspan="4">2006
3Q – 100%</td><td rowspan="4">LINK report
(ROM supplemental report)</td><td>A) Continuous tracking and quality improvement process utilizing data reports on caseload standards (AO/CO).</td><td>Ongoing.</td></tr>
<tr><td>B) Converted the existing durational social work positions into 25 permanent social work positions. Remaining 27 will stay as durational and filled by department as needed. An additional 9 durational staff will be added to staff.</td><td>Completed.</td></tr>
<tr><td>C) Monitor social worker staffing levels through Human Resources, maintain a candidate pool and streamline hiring process for these positions.</td><td>Reports on vacancies and offers are ongoing. Live Scan for quicker background checks in operation, and changes were made to application to allow for background checks to begin prior to hiring.</td></tr>
<tr><td>D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.</td><td>Ongoing.</td></tr>
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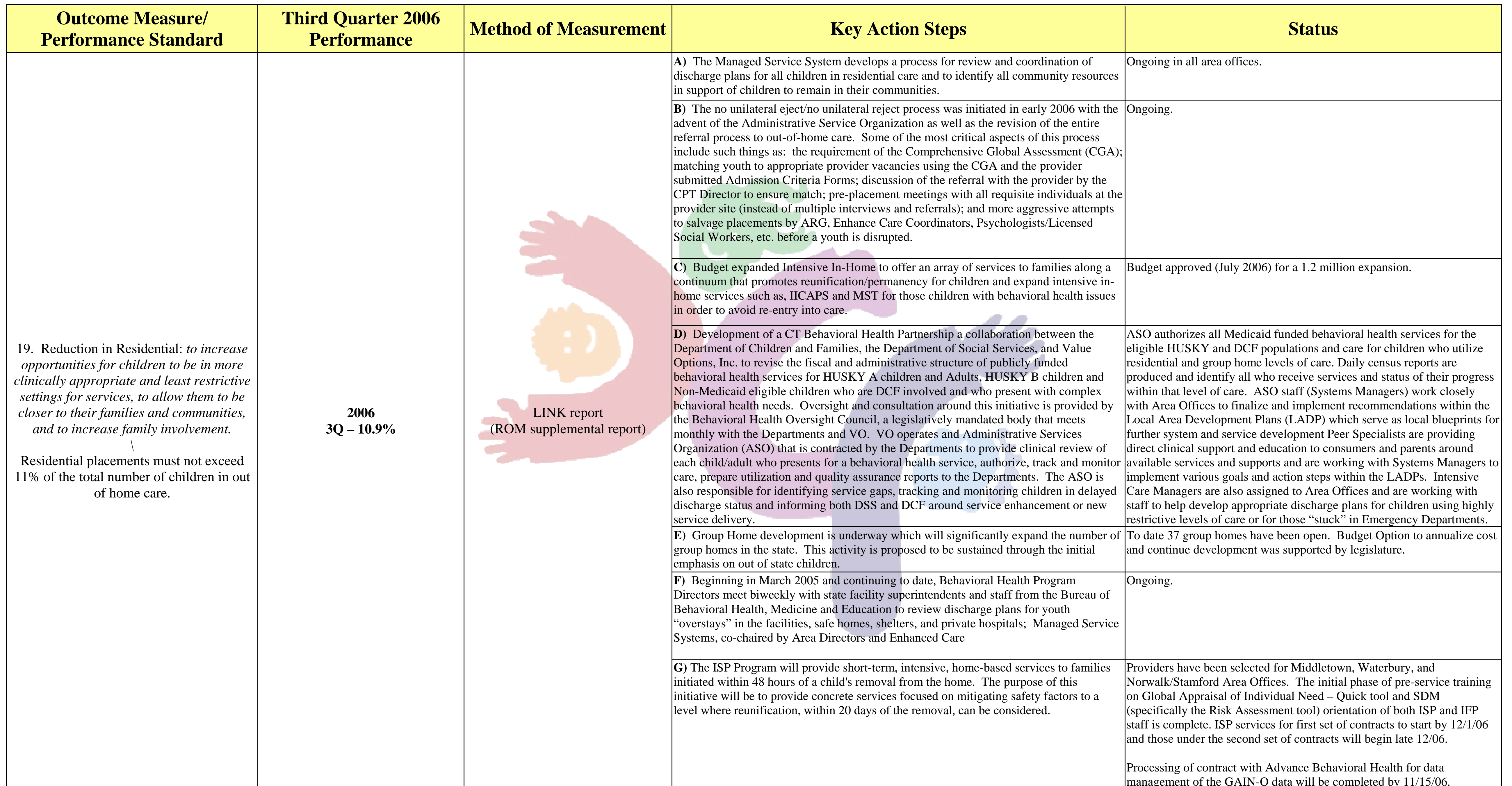
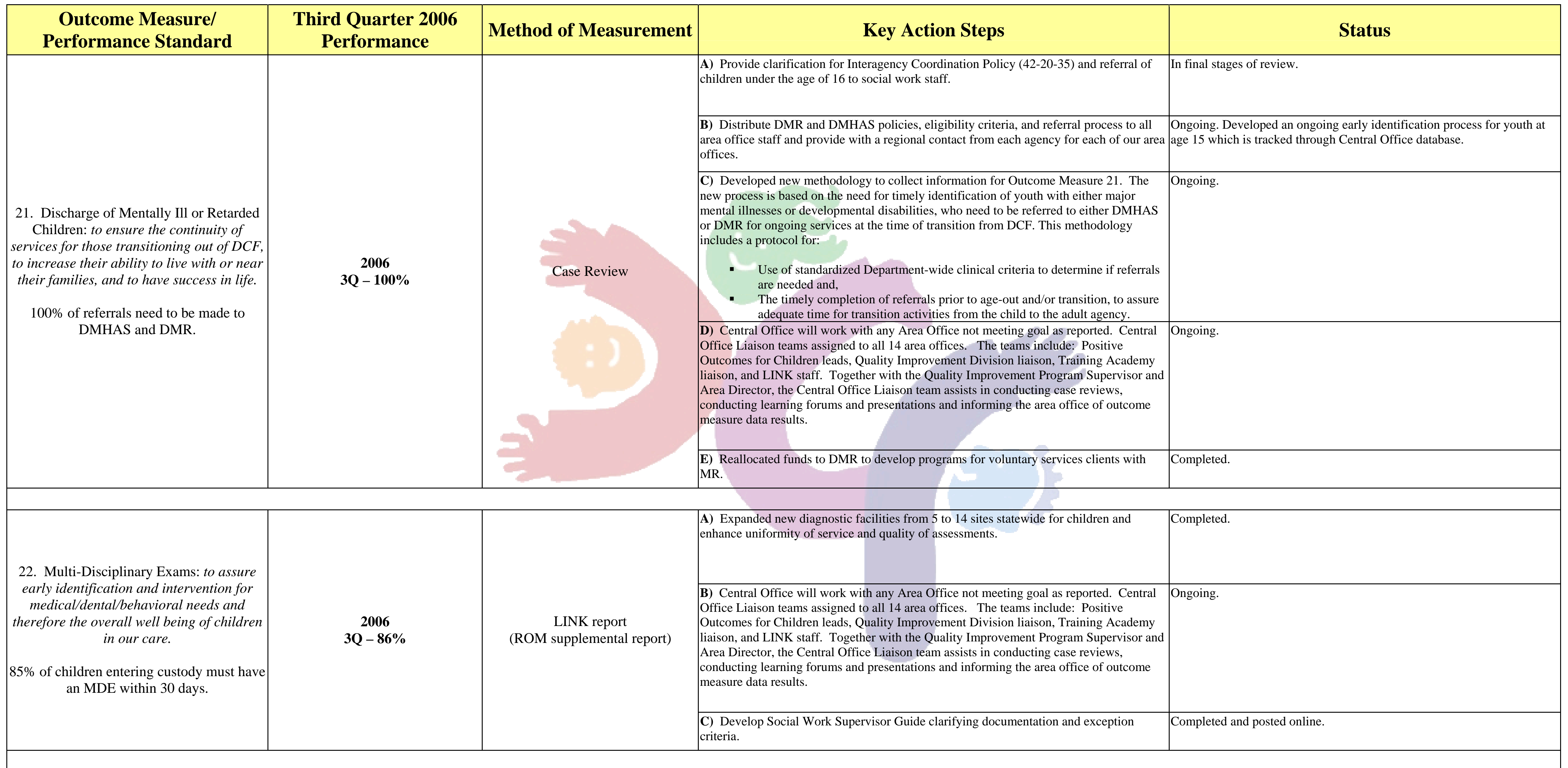


Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
19. Reduction in Residential: *to increase opportunities for children to be in more clinically appropriate and least restrictive settings for services, to allow them to be closer to their families and communities, and to increase family involvement.* \ Residential placements must not exceed 11% of the total number of children in out of home care.	**2006 3Q – 10.9%**	LINK report (ROM supplemental report)	**A)** The Managed Service System develops a process for review and coordination of discharge plans for all children in residential care and to identify all community resources in support of children to remain in their communities.	Ongoing in all area offices.
			B) The no unilateral eject/no unilateral reject process was initiated in early 2006 with the advent of the Administrative Service Organization as well as the revision of the entire referral process to out-of-home care. Some of the most critical aspects of this process include such things as: the requirement of the Comprehensive Global Assessment (CGA); matching youth to appropriate provider vacancies using the CGA and the provider submitted Admission Criteria Forms; discussion of the referral with the provider by the CPT Director to ensure match; pre-placement meetings with all requisite individuals at the provider site (instead of multiple interviews and referrals); and more aggressive attempts to salvage placements by ARG, Enhance Care Coordinators, Psychologists/Licensed Social Workers, etc. before a youth is disrupted.	Ongoing.
			C) Budget expanded Intensive In-Home to offer an array of services to families along a continuum that promotes reunification/permanency for children and expand intensive in-home services such as, IICAPS and MST for those children with behavioral health issues in order to avoid re-entry into care.	Budget approved (July 2006) for a 1.2 million expansion.
			D) Development of a CT Behavioral Health Partnership a collaboration between the Department of Children and Families, the Department of Social Services, and Value Options, Inc. to revise the fiscal and administrative structure of publicly funded behavioral health services for HUSKY A children and Adults, HUSKY B children and Non-Medicaid eligible children who are DCF involved and who present with complex behavioral health needs. Oversight and consultation around this initiative is provided by the Behavioral Health Oversight Council, a legislatively mandated body that meets monthly with the Departments and VO. VO operates and Administrative Services Organization (ASO) that is contracted by the Departments to provide clinical review of each child/adult who presents for a behavioral health service, authorize, track and monitor care, prepare utilization and quality assurance reports to the Departments. The ASO is also responsible for identifying service gaps, tracking and monitoring children in delayed discharge status and informing both DSS and DCF around service enhancement or new service delivery.	ASO authorizes all Medicaid funded behavioral health services for the eligible HUSKY and DCF populations and care for children who utilize residential and group home levels of care. Daily census reports are produced and identify all who receive services and status of their progress within that level of care. ASO staff (Systems Managers) work closely with Area Offices to finalize and implement recommendations within the Local Area Development Plans (LADP) which serve as local blueprints for further system and service development Peer Specialists are providing direct clinical support and education to consumers and parents around available services and supports and are working with Systems Managers to implement various goals and action steps within the LADPs. Intensive Care Managers are also assigned to Area Offices and are working with staff to help develop appropriate discharge plans for children using highly restrictive levels of care or for those "stuck" in Emergency Departments.
			E) Group Home development is underway which will significantly expand the number of group homes in the state. This activity is proposed to be sustained through the initial emphasis on out of state children.	To date 37 group homes have been open. Budget Option to annualize cost and continue development was supported by legislature.
			F) Beginning in March 2005 and continuing to date, Behavioral Health Program Directors meet biweekly with state facility superintendents and staff from the Bureau of Behavioral Health, Medicine and Education to review discharge plans for youth "overstays" in the facilities, safe homes, shelters, and private hospitals; Managed Service Systems, co-chaired by Area Directors and Enhanced Care	Ongoing.
			G) The ISP Program will provide short-term, intensive, home-based services to families initiated within 48 hours of a child's removal from the home. The purpose of this initiative will be to provide concrete services focused on mitigating safety factors to a level where reunification, within 20 days of the removal, can be considered.	Providers have been selected for Middletown, Waterbury, and Norwalk/Stamford Area Offices. The initial phase of pre-service training on Global Appraisal of Individual Need – Quick tool and SDM (specifically the Risk Assessment tool) orientation of both ISP and IFP staff is complete. ISP services for first set of contracts to start by 12/1/06 and those under the second set of contracts will begin late 12/06. Processing of contract with Advance Behavioral Health for data management of the GAIN-Q data will be completed by 11/15/06.

Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
20. Discharge Measures: *to ensure life skills and work/educational credentials before transitioning out of DCF so that they may have success as independent members of their communities.* For 85% of adolescents. Must be documented in LINK. Re; Diplomas, college, GED, employment, or military.	**2006** **3Q – 100%**	Case Review	**A)** Develop alternative approaches aimed at doing outreach in the community (e.g. employers, support services, mentors, special training for foster/adoptive parents). Collaborate with the Department of Labor on youth employment opportunities under WIA to support young adults in their lifelong interests.	DCF and DOL meeting to ensure priority access, ongoing referrals and maintaining youth in programs. DCF and DOL have collaborated on an RFP for a Work to Learn Program in the New Haven area. DOL has provided support and funding for data collection.
			B) Repositioned Adolescent Services within Department to bring greater focus to the needs of this target population and will enhance services and program support for independent living. **1.** Life skills training expansion. **2.** The Department in conjunction with the Department's of Social Services, Mental Health and Addictive Services, Economic Development, Office of Policy and Management and Connecticut Home Finance Authority will establish a Supportive Housing pilot for young adults transitioning from homelessness or youth systems (e.g. foster care or residential facilities).	The DCF continues to offer Train the User and Train the Trainer training around the Ansell-Casey Life Skills Program to DCF staff, Community Providers including residential, group home, SWETP and CHAP staff, Community Life Skills providers and Staff from the Connecticut DMHAS Youth Adults Program. To date 40 people have been trained as "Users" (only uses the program) and 10 people as "Trainers" (trains the program and is also a user) with another group receiving user training this November 2006. The DCF along with CHFA and a number of other State agencies have awarded contracts for Supportive Housing to 7 community providers for fiscal year 2006. RFPs for additional slots will be offered over the next 5-9 months.
			C) Develop alternative approaches aimed at doing outreach in the community (e.g. employers, support services, mentors, special training for foster/adoptive parents). Establish pilot with CT. Voices for Children in Hartford (40 slots) and Bridgeport (35 slots) (CT. Jim Casey Youth Opportunities Initiative) that serves to help youth transition successful from the foster care system.	The DCF continues to work with 75 youth in Bridgeport and Hartford around the Jim Casey Project and the Work to Learn Model. In addition, the Department has recently 11/1/06 awarded a contract to Marrakesh Inc. to provide a Work to Learn program, modeled after the Casey Project, for 60 New Haven area youth. This model is highlighted by the collaboration of many public agencies including Ct. Dept. of Labor, Governor's Prevention Partnership, State Board of Education, Ct. Court Supports Services Division and the New Haven Board of Education. The program is available for youth ages 14 to 21 involved with the DCF. An additional 20 slots have been purchased by CSSD for 16 and 17 year old youth involved in the adult court system's probation department.
			D) Work with Adolescent Units to resurrect adolescent advisory boards utilizing a regional format.	Ongoing.
			E) Implement pilot program at High Meadows with an emphasis on job coaching and job training to help with transition.	Implemented December 1, 2005 with 8 youth participating.
			F) TLAP Expansion - budget doubled from 3 to 6 the number of TLAP programs.	Expansion targeted for February 2007.
			G) Develop system to identify Adolescents (18+ years) that are in ILP/CHAPS program for reporting purposes.	Completed LINK enhancement.



Outcome Measure/ Performance Standard	Third Quarter 2006 Performance	Method of Measurement	Key Action Steps	Status
21. Discharge of Mentally Ill or Retarded Children: *to ensure the continuity of services for those transitioning out of DCF, to increase their ability to live with or near their families, and to have success in life.* 100% of referrals need to be made to DMHAS and DMR.	**2006** **3Q – 100%**	Case Review	**A)** Provide clarification for Interagency Coordination Policy (42-20-35) and referral of children under the age of 16 to social work staff.	In final stages of review.
			B) Distribute DMR and DMHAS policies, eligibility criteria, and referral process to all area office staff and provide with a regional contact from each agency for each of our area offices.	Ongoing. Developed an ongoing early identification process for youth at age 15 which is tracked through Central Office database.
			C) Developed new methodology to collect information for Outcome Measure 21. The new process is based on the need for timely identification of youth with either major mental illnesses or developmental disabilities, who need to be referred to either DMHAS or DMR for ongoing services at the time of transition from DCF. This methodology includes a protocol for: ▪ Use of standardized Department-wide clinical criteria to determine if referrals are needed and, ▪ The timely completion of referrals prior to age-out and/or transition, to assure adequate time for transition activities from the child to the adult agency.	Ongoing.
			D) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			E) Reallocated funds to DMR to develop programs for voluntary services clients with MR.	Completed.
22. Multi-Disciplinary Exams: *to assure early identification and intervention for medical/dental/behavioral needs and therefore the overall well being of children in our care.* 85% of children entering custody must have an MDE within 30 days.	**2006** **3Q – 86%**	LINK report (ROM supplemental report)	**A)** Expanded new diagnostic facilities from 5 to 14 sites statewide for children and enhance uniformity of service and quality of assessments.	Completed.
			B) Central Office will work with any Area Office not meeting goal as reported. Central Office Liaison teams assigned to all 14 area offices. The teams include: Positive Outcomes for Children leads, Quality Improvement Division liaison, Training Academy liaison, and LINK staff. Together with the Quality Improvement Program Supervisor and Area Director, the Central Office Liaison team assists in conducting case reviews, conducting learning forums and presentations and informing the area office of outcome measure data results.	Ongoing.
			C) Develop Social Work Supervisor Guide clarifying documentation and exception criteria.	Completed and posted online.