Department of Children and Families
CQI / QA Processes

CT DCF promotes a culture of continuous learning and quality improvement with the end goal of improving outcomes for the children and families we serve. The Bureau of Strategic Planning has continued to collaborate with the Child Welfare Division and other agency divisions to ensure that ongoing quality assurance reviews and protocols are completed to review the quality of our work and practice. The Bureau also ensures that this data is shared with agency staff to guide quality improvement efforts and strategies to improve the practice. DCF has historically been identified as having strong CQI and QA processes, recently recognized by the federal Child and Family Services Reviews (CFSR). To improve and further develop our CQI work, DCF recognized the value in centralizing the agency's CQI work and also noted the need to establish a statewide and agency wide CQI framework. While this restructuring and centralization of CQI staff continues, the QA and QI work has continued to analyze and assess the practice and provide that data and feedback to staff to inform quality improvement efforts.

The Bureau of Strategic Planning conducts multiple QA reviews including both ongoing reviews and ad-hoc reviews as needed to respond to any questions or concerns pertaining to the practice with children and families. These Quality Assurance reviews include the following:

Administrative Case Reviews: Ongoing periodic reviews are completed to assess the case plan and case goal for every child in DCF care. A case plan is written for each child in DCF care including a summary of their medical, behavioral, and mental health status and needs, as well as a description of their current placement, educational status, case goal, and other information. This case plan is written and reviewed via the Administrative Case Review (ACR) process within 60 days of the child's entry into DCF care, and the case plan is updated and reviewed every 6 months thereafter while the child remains in DCF care until he/ or she achieves permanency and exit from DCF care. These reviews are conducted in a meeting with invited family members, caretakers, and involved service providers, and the results of the meeting and the case review are documented in the ACR tool. This standardized ACR tool captures federal (CFSR) items pertaining to safety, permanency and well-being. The ACR process also includes reviews of family cases associated with children in care (within certain parameters) and these case reviews assess safety and risk factors for those family cases. The ACR data is aggregated and available in the ACR Case Practice Data Report. In 2022, there were 9,137 Administrative Case Reviews completed.

Differential Response System (DRS) Reviews: Ongoing monthly reviews are completed utilizing a standardized tool to examine the DRS practice (both Intake and FAR cases) in each area office, as well as the Special Investigations and Education Professional Investigations Units. This tool assesses multiple areas of DRS practice including risk and safety assessment and safety planning, contact with children and adult household members, supervision and oversight of the cases, and timely service referral and provision to the family. 80 cases are reviewed per month by Strategic Planning staff and the results of these reviews are shared with the CPS staff and Leadership and are discussed at area office and regional CQI team meetings. The DRS practice data is aggregated and shared monthly by QI staff. 942 cases were reviewed in 2022.

Non-Accept Report Reviews: Ongoing periodic reviews are completed to ensure that the DCF Careline is appropriately screening in reports that meet the threshold of suspected abuse or neglect. Strategic Planning staff utilize a standardized tool to review a sample of Non-Accept (NA) reports to assure the designation was made through the appropriate application of Careline SDM tools and critical thinking. The review results for 2021 and 2022 were aggregated and the review results were shared via a report with DCF CPS staff and CPS Leadership, as well as with Careline staff and Leadership to ensure strategic follow up and practice improvement. In 2021, a total of 3510 non-accepted/screened out reports were reviewed through this QA process. In 2022, there were an additional 950 non-accepted reports reviewed.

Child and Family Services Reviews (CFSR)/ Program Improvement Plan (PIP) reviews: Ongoing monthly reviews are completed utilizing the federal On-Site Review Instrument (OSRI) which provides a comprehensive examination of case practice through these reviews completed by Strategic Planning staff. Connecticut DCF successfully completed and exited the Program Improvement Plan (PIP) in 2021, which resulted from the CFSR review process in 2016. DCF elected to continue the PIP review process to ensure that ongoing reviews have continued, utilizing the CFSR lens to examine our work to ensure safety, permanency, and well-being for both children in placement and family cases served by DCF. These comprehensive review results are then shared with CPS staff and Leadership, including review of the individual case results with the assigned CPS team. 64 reviews were completed in 2022.

Critical Incident Summary Reviews: Reviews are completed by Strategic Planning staff utilizing a standardized summary format for specific cases. The criteria for the review includes all cases in which a Critical Incident is received on a family that has active involvement

with the Department or recent involvement, defined as involvement within the most recent 12 months; in these cases a Quality Improvement or Quality Assurance Program Supervisor conducts a review, inclusive of administration of the SSIT (Safe Systems Improvement Tool) to complete a brief case summary including an assessment of case practice strengths and practice concerns. These Critical Incident Summary Reviews are separate from the Special Qualitative Review (SQR) assessments completed by Academy for Workforce Development staff, that are completed for fatality and "near miss" cases. The review results are then shared with the entire CPS chain of command team and CPS Leadership. 37 reviews were completed in 2022.

Sibling Visitation Reviews: Annual reviews are completed utilizing a standardized tool to examine the DCF practice regarding ensuring regular sibling visitation for all children in DCF care, as required per state statute. The review assesses the visitation for a sample of children in DCF care and each child's visitation with their siblings (including adult siblings) is evaluated and compliance with the statute is operationalized at the target child and sibling level, resulting in measurement for sibling pairs. 286 reviews were completed in 2022.

In-Home Case Reviews: The standardized tool to provide a comprehensive review of practice on in-home cases has been revised and updated to include areas of assessment beyond visitation. The revised tool examines all aspects of practice for in-home cases, not just visitation. The new tool contains additional areas of review focus including supervision and oversight of the case, Safety Planning Practice including assessment of utilization of the ABCD Child Safety Practice Model, and service provision for families. A pilot review was completed in February, and the plan is to resume IH case reviews in April 2023 following the establishment of the Case Practice Review Unit within Strategic Planning.

Safety Plan and Family Arrangement Reviews: Pertaining to the question regarding the DCF response to child fatalities and near-fatalities resulting from exposure to fentanyl and other safety factors, DCF embraced a Continuous Quality Improvement Plan-Do-Study-Act (PDSA) cycle to examine the case practice, determine any case practice concerns, and implement Quality Improvement strategies to address the identified case practice issues. In Q1-22, a qualitative review was completed regarding a sample of cases from each area office with a Safety Plan in place, to provide a snapshot view of the quality of the Department's safety planning practice with families, as well as the documentation of the safety planning process due to some concerns identified through Critical Incident reviews and other cases. The review indicated opportunities for improvement in the safety planning practice.

Following the review, a planning team inclusive of Child Welfare, Legal, Clinical and Community Consultation, Academy for Workforce Development, Strategic Planning, and other divisions was formed to develop the Safety Practice Guidance as a supplement to the overall Child Safety Practice Model. This guidance was provided in August of 2022, and in November 2022 a Safety Summit was held with all DCF leaders to reinforce and discuss the Child Safety Practice Model. Since the promulgation and implementation of the Safety Practice Guidance, there has been ongoing training and dialogue to review aspects of the Child Safety Practice Model; this includes facilitated discussions in each area office co- facilitated by the Office Directors and Staff Attorneys, as well as virtual statewide meetings facilitated by the Academy for Workforce Development.

Additionally, in October 2022 a protocol was implemented specific to cases with parents impacted by fentanyl use. This protocol ensures clear guidance and oversight for cases with fentanyl concerns, to include specific assessment for any case in which active fentanyl use is alleged, suspected, or confirmed by the parent's admission, as a Safety Plan is being developed. This assessment includes both a Regional Resource Group (RRG) substance use consult, as well as a meeting with the Principal Attorney, CPS team (SW, SWS, PS) and RRG to discuss the case and safety concerns and develop multidisciplinary strategies regarding the best way to assess use and ensure child safety. Both the RRG consult and the subsequent team meeting are required to occur within one business day. This protocol and practice continues currently to ensure the safety of children residing in families affected by fentanyl use.

In December 2022, a subsequent comprehensive review was conducted regarding cases with implemented Safety Plans and/ or Family Arrangements. This review provided an updated assessment of the practice related to the utilization and implementation of safety plans and family arrangements for children and provided an opportunity to offer quality feedback to DCF child welfare leadership to inform ongoing CQI efforts relative to safety planning with families. This work represents continuous quality improvement (CQI) work in action, through the identification of opportunities for improvement, the steps taken to address and improve the practice, and follow up reviews to assess the efficacy of the steps and strategies as well as the practice. In total, 335 Safety Plan and/or Family Arrangement reviews were completed in 2022.

There are additional ad-hoc reviews that have been completed, including the following: a review of children with a "short stay" in DCF care to assess the practice regarding removal of children and permanency for those children; a review of youth and young adults receiving Services Post-Majority (SPM) DCF services to assess the practice with this population; a review of legal planning and permanency for children and youth in two Juvenile Court jurisdictions to assess factors associated with timely permanency and legal disposition; and other reviews. Some of these reviews will be implemented as additional regular ongoing reviews with the establishment of the Case Practice Review Unit within Strategic Planning.

It is noted that the quality assurance protocols and reviews are completed with the explicit purpose of case practice improvement- our goal is to improve our practice with the children and families we serve. To that end, we continue to ensure that the data is carefully analyzed and performance improvement strategies are determined based upon that data. Attention is paid to the trends and themes in case practice utilizing this data, and quality improvement strategies and modifications to practice are based upon the data as part of the continuous quality improvement cycle.

One aspect of our continuous quality improvement cycle is the ChildStat process which was launched in April 2021. This is a CQI and management process to assess agency performance which allows staff to review and present data specific to key outcome measures and discuss strategies for improvement. The ChildStat presentations are attended by statewide Leadership and offer opportunities for communication related to practice, performance and strategies for improvement. Each office and/or division presents on the same performance measures which align with our operational Key Results, which are also consistent with the Federal Performance Measures. ChildStat has pushed agency leadership to take a critical look at performance and conduct further reviews to understand the story behind the data, and improvement strategies are tracked to assess efficacy and practice improvement. If the strategies do not appear to be working, then the strategies are revised; this is part of the PDSA cycle that is utilized by DCF. The ChildStat meetings will continue and in true CQI form, this process will be iterative and adjustments continue to be made based on lessons learned along the way.

Another aspect of our continuous quality improvement work relates to the Special Qualitative Review (SQR) assessments completed by Academy for Workforce Development staff. The SQR assessments include interviews with DCF staff and external stakeholders in addition to the review of the case circumstances, and the areas of case review focus include: case practice concerns, system concerns, policy concerns, and strengths of the work. The SQR assessment method includes process mapping of themes to identify areas of system change, and the results of the SQR reviews are shared with Leadership and CPS staff to ensure continued learning and practice improvement. Additionally, DCF participates in the national Redcap process through the SQR reviews, and Connecticut data is entered in the Redcap Database; this helps to inform the national child welfare work as well as the CT DCF work. SQR Learning Forums have also been held with CPS staff based upon themes of the SQR reviews. There have been multiple Learning Forums held to date, including forums on "Timely and Appropriate Service Delivery" and most recently a forum on "Fentanyl Use in Families and Child Protection Implications."

The above are examples of continuous quality improvement practices which ensure thorough and systematic communication about the data and ensure continued learning through analysis of the data and identification of practice improvement strategies.