

Maryland's
Department of Human Resources -
Social Services Administration
and
Local Departments of Social Services
Child Welfare
Continuous Quality Improvement
Policies and Procedures Manual

Fiscal Years 2010 -2012
(Pilot Manual)

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Note

This manual is considered a Pilot Manual, as there are additional policies currently under development. The policies and procedures included here, however, will be followed for the first two to three Local Department of Social Services (LDSS) reviews, and all LDSSs will begin to engage in the Continuous Quality Improvement process. A separate implementation plan will be distributed, and a final manual will be published later in spring/summer 2010.

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Introduction to the DHR/SSA – LDSS Child Welfare Continuous Quality Improvement Process

“ . . . quality improvement is a process, not an event. In part it works by finding variation and drawing attention to it. . . And well-done quality improvement is not punitive; it’s educational.”

(Ware Branch, quoted in “Making Health Care Better,” David Leonhardt, The New York Times, 11/8/09)

The Maryland Department of Human Resources/Social Services Administration (DHR/SSA) – Local Department of Social Services (LDSS) Child Welfare Continuous Quality Improvement (CQI) Process is designed to improve outcomes for children and families involved in the child welfare system, utilizing a collaborative partnership between DHR/SSA and Maryland’s 24 LDSSs to evaluate current performance and outcomes, assess areas of strengths and areas needing improvement, and develop and monitor plans to improve LDSS child welfare practice. Child safety, permanency, and well-being are the central goals of Maryland’s child welfare system, and are the primary focus of the CQI process.

Underlying this process are data and information strategies designed to assess the state of our current child welfare performance, and most importantly, begin to identify causes when and if this performance does not meet expected standards. Thus, the CQI process is designed to answer the question, ‘what are the underlying causes to the gap between our required activities, our expected performance and outcomes, and our actual performance and the actual outcomes our children, families, and communities experience?’

Once we acquire this knowledge at the local level, strategies can be formulated to address these issues; careful monitoring will continue to evaluate the impact of these interventions. Statewide information regarding underlying causes to these gaps, and information gained on what works and doesn’t work, combined with expertise from child welfare research and input from our local, state, and national stakeholders, will be used to drive policy and practice decisions.

Within the CQI Process, DHR/SSA and the LDSSs are viewed as equal partners with unique knowledge, expertise, and resources that can be brought to bear on the shared goal of improving outcomes for children and families. DHR/SSA will coordinate the CQI Process, act as a consultant on data analysis, provide data and reports to the LDSS, and lead the Targeted Quality Assessment Review (which includes case reviews and on-site reviews). Meanwhile, the LDSS will have the responsibility of interpreting the meaning and causes of specific data trends, and prioritizing and implementing strategic interventions. Both DHR/SSA and the LDSSs will share the responsibility of designating areas of strength and areas needing improvement (ANIs) and determining long-term and interim goals for improvement. Both will also regularly review progress made on these strategies, review aggregate data, and recommend course-corrections when needed. Additionally, data gathered by DHR/SSA through the CQI processes of each LDSS will be used to identify statewide systemic and organizational challenges to effective case work practice, and DHR/SSA will seek to address these.

Child welfare outcomes are expected to improve through the use of evidence-based and clinically appropriate interventions, improvements in efficiency and effectiveness, critical analysis of data, and strategic investment of resources. As Maryland’s child welfare practice includes the use of MD CHESSE for all case documentation, the CQI Process will review and report on MD CHESSE data entry, and will

rely on MD CHESSIE as the source for monitoring data.¹ Improved use and understanding of data in policy and practice decision-making is an additional expected outcome from the CQI Process.

The major components of the CQI Process are the Quality Assessment Review (QAR), the Targeted Quality Assessment (QA) Review, and the Continuous Quality Improvement Plan (CQI Plan). The LDSS develops the QAR through a process of self-assessment, data analysis, and local stakeholder focus groups. The Targeted QA Review includes case reviews and an on-site review, based on the QAR and led by DHR/SSA QA staff. The CQI Plan is developed by the LDSS (in consultation with DHR/SSA) and uses the QAR and the Targeted QA Review as its basis, and includes strategies to improve outcomes and achieve established goals. The CQI Plan will be designed to implement and measure changes over a three year period, and will be monitored on a semi-annual basis. Additional data and monitoring will be provided by DHR/SSA on a monthly and semi-annual basis.

The CQI Process is intended to support the work of the LDSS, and should be viewed as a local department's opportunity to utilize consultation and support from DHR/SSA to develop and implement local strategic interventions. Departments with current strategic plans, self-assessments, and/or internal CQI/Quality Assurance plans should use these as a basis for the QAR and CQI Plan. Current local and state initiatives and strategies may form the basis of the CQI Plan if they address identified areas needing improvement, although additional or new strategies may be needed to address other issues.

In order to provide consistent and current expertise relating to child welfare practice, DHR/SSA Child Welfare Practice and Policy staff will assist in:

- the review of identified ANIs and strengths;
- selected portions of the Targeted QA Review (specifically, selected case review items); and
- the review of the LDSS's CQI Plan.

Due to DHR's responsibilities to the Governor, the Maryland legislature, and the federal government, DHR/SSA approval will be required for local departments' QARs and CQI Plans, after discussion and consultation with the LDSS. These responsibilities may also require DHR/SSA to include specific indicators or strategies within LDSS CQI reports and plans (and/or additional monitoring), in order to fulfill state and federal requirements.

The CQI Process will rely on the Results Accountability (RA) framework² to organize and provide context for data indicators. The RA approach focuses on the three main types of data as well as analysis and contextual information:

1. How much did we do?;
2. How well did we do it? (may be conceptualized as fidelity to practice models, or process and quality measures);
3. Is anyone better off? (may be conceptualized as outcomes); and
4. The "story behind the data." (may be conceptualized as analysis of the meaning, causes, and consequences of both positive and negative trends).

Child safety, permanency, and well-being are a primary focus of the CQI Process. Each of the five current program assignment areas will be reviewed during the CQI Process (Investigations, In-Home

¹ Data from previous information systems and 'hand counts' may be used to establish past performance and baselines; selected indicators may also rely on 'hand counts' until if this data is accepted for State Stat reports.

² Friedman, Mark. 2005. *Trying Hard is Not Good Enough*. (British Columbia: Trafford Publishing).

Services, Out-of-Home Services, Adoptions, and Resource Homes). In addition to these program areas, auxiliary services, workforce/workspace issues, and systemic areas will also be addressed.

Fidelity to Maryland's child welfare practice models (the "how well did we do it?" indicators) will be expected to exceed 95% (unless otherwise indicated); data indicating less than 95% adherence to practice requirements will be considered an indication of an area needing improvement. For any identified area needing improvement, DHR/SSA and the LDSSs are expected to share responsibility for implementing and monitoring changes to address these areas. Specific DHR/SSA and LDSS responsibilities will be individually determined based on the area needing improvement, strategies selected by the LDSS, available resources, and other factors.

This manual offers an overview of the purpose and structure of the CQI process, as well as provides specific requirements, templates, and timelines. The manual is designed to assist DHR/SSA QA and LDSS staff in planning for and conducting the local jurisdiction's CQI process. Templates and forms are included in the Appendices (and on SSANet). DHR/SSA QA staff will provide additional guidance to LDSS staff through planning meetings, telephone calls and other methods. Technical assistance on the development and implementation of the QAR and CQI Plan is available to each LDSS from the DHR/SSA Quality Assurance unit. Each LDSS will be assigned a DHR/SSA QA staff member as their primary point of contact, but additional assistance may also be provided by other members of the QA team, the supervisor and manager of the QA team, and other SSA staff.

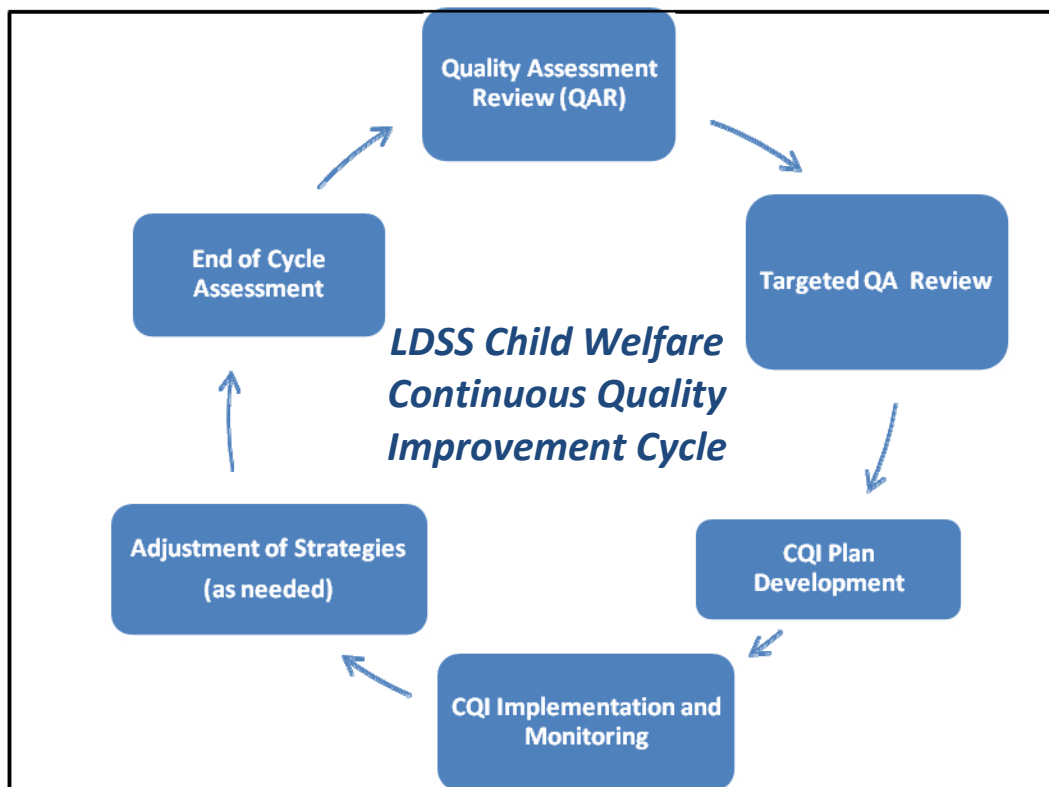
Overview of the DHR/SSA – LDSS Child Welfare CQI Process

The major components of the DHR/SSA – LDSS Child Welfare Continuous Quality Improvement Process are the Quality Assessment Review (QAR), Targeted Quality Assessment (QA) Review, and the Continuous Quality Improvement Plan (CQI Plan). The LDSS develops the QAR through a process of self-assessment, data analysis, and local stakeholder focus groups. The Targeted QA Review is led by DHR/SSA QA staff, and involves case reviews, case-related interviews, stakeholder interviews, and additional data reports (as needed). Lastly, the LDSS will develop the CQI Plan, using the findings of the QAR and the Targeted QA Review as its basis. The CQI Plan will describe and prioritize strategies to improve outcomes and performance measures over a three year period, and establish long-term and interim goals, with progress reviewed by DHR/SSA and the LDSS on a semi-annual basis (every six months). This plan will be monitored on a regular basis by both the LDSS and DHR/SSA.

A typical CQI cycle for an LDSS will include the following schedule (over a three year period):

1. Quality Assessment Review (QAR)
2. Targeted QA Review
3. CQI Plan Development
4. Implementation of CQI Plan, and CQI Plan Monitoring
5. Adjustment of strategies (as needed)
6. End of Cycle Assessment

Figure 1



The LDSS Child Welfare Quality Assessment Review (QAR)

Purpose of the Quality Assessment Review

The Quality Assessment Review (QAR) process is designed to assess each local Department of Social Service's effectiveness in protecting children from abuse and neglect, identify areas of strengths and areas needing improvement, and lead to the development of a Continuous Quality Improvement Plan to maintain (or improve) areas of strength and to address areas needing improvement (ANIs).

Description of the QAR Process, Format, and Frequency

Each local DSS will engage in the QAR process every three fiscal years, with approximately eight DSSs participating in the QAR each fiscal year.

The QAR is designed to be data-driven document, with liberal use of data tables and graphs. Narrative sections should be used primarily to provide context and non-data information. The QAR report will need approval by DHR/SSA staff to ensure that both the LDSS and DHR/SSA agree on all identified areas of strength and areas needing improvement (SSA input will be provided by both QA and Child Welfare Practice and Policy staff as well as others, as needed). The results of the Targeted QA Review could, however, lead to a reassessment of specific indicator's categorization as an ANI or strength.

Data and Data Analysis

At the beginning of the QAR development process, DHR/SSA QA staff will provide the LDSS with aggregate data on Primary and Secondary indicators used in the QAR (excluding auxiliary services, workforce/workplace issues, and systemic factors; the LDSS is responsible for providing data for these sections). When possible, this data will be accompanied by trend analysis, baselines, and comparison to state and national trends and standards. It is expected that the LDSS use this information in several ways:

- As one basis for discussion during stakeholder focus groups;
- Identifying areas of strength and areas needing improvement (ANIs); and
- Developing and prioritizing strategies to correct ANIs.

Data and data analysis provided by DHR/SSA for each indicator is required to be included in the QAR, and the LDSS is responsible for providing the 'story behind the data' for each indicator. This information should include contextual information, causes of (positive and negative) trends, the meaning and significance of the data, and the probable consequences of data trends.³ This analysis of the underlying dynamics of data trends depends on the unique circumstances of the jurisdiction, the LDSS, and the child welfare client population.

³ For example, if an LDSS is found to have decreasing numbers of reunifications: the context may be changes in the jurisdiction's overall population, resources, judicial preferences, etc.; the causes may be decreases in the overall OOH population, an increase in severe child abuse/neglect cases that result in TPR, lack of resources to support family success at reunification, etc; the meaning/significance may be that more children are suffering from more severe incidents of abuse/neglect; the consequences may be an increase in the number of children in care, increase lengths of stay, increase in adoptions, etc.

Components of the QAR

Below is a description of the required elements of the QAR; please see Appendix B for a complete list of required elements and the required template/format.

Description of the LDSS and Jurisdiction

Information presented in this section should provide needed context for understanding the LDSS's specific data. This includes information on the geographic and demographic composition of the jurisdiction, communities and populations served, child welfare services provided by the LDSS, significant events/issues affecting the LDSS/jurisdiction (i.e. recent influx of population, recent decline in a major employer, increase in crime, etc.). Basic population data should be provided (total population, child population, age groups, racial and ethnic data, general education and economic levels, predominant family structures, etc.). An overview of specific child welfare programs and workforce should also be included.

Stakeholder Input

The LDSS is required to hold a series of stakeholder focus groups, designed to elicit community feedback on the strengths and weaknesses of the jurisdiction's child welfare system. While the LDSS may be the most visible part of the child welfare system, families, the judicial system, service providers, police, community, and other entities play an important role, and input on the workings of the entire system should be discussed. Both internal and external stakeholder focus groups should be held.

Recommendations for improvements should also be sought from these groups, as stakeholders will become integral partners in achieving the goals of the CQI Plan. See Appendix B for a list of stakeholders who should be included in this process.

Identification of Areas of Strength and Areas Needing Improvement

Based on data analysis and stakeholder input, the LDSS will identify preliminary areas of strength and areas needing improvement. At the time of the submission of the QAR, DHR/SSA staff will review this assessment, provide feedback if needed, and approve the document (or send back for revisions). The goal of DHR/SSA approval is not to 'second guess' the local Department's analysis, but to ensure that all data and factors were considered when designating strengths and ANIs.

This step also allows DHR/SSA QA staff to prepare case review samples based on targeted populations (based on relevant issues). If there are new or additional state or federal indicators that the State is required to address, this is one point at which they may be added to the LDSS's QAR.⁴

Indicators

Primary indicators will be used to focus on critical areas of child safety, permanency, and well-being. In addition to these primary indicators, secondary indicators required by state and federal policy will also be included. Primary indicators were selected based on critical performance and outcome measures of child welfare practice, and their ability to serve as 'proxy' measures for the secondary indicators; that is,

⁴ If new state or federal requirements are established after the approval of the QAR and/or CQI Plan, amendments may be made to those documents.

if an LDSS is performing well on a primary indicator, it is likely that the LDSS is also performing well on related secondary indicators. Progress on all indicators will be measured; the use of primary indicators is designed to focus both DHR/SSA and LDSS's efforts in a time- and resource- efficient manner.

Please note that data on primary and secondary indicators will be stratified by age and other child/situation characteristics whenever appropriate and possible. Therefore, indicators will be assessed separately by these stratifications, with designations of ANIs and strengths specific to each stratification.⁵ When possible, entry cohort data will be used in lieu of exit cohort or point in time cohorts.

Data will be presented by State Fiscal Year quarter whenever possible.

Please see Appendix B for primary and secondary indicators.

Potential data sources for the QAR:

- Administrative data
 - Place Matters (State Stat template)
 - StateStat reports
 - Maryland's CFSR data profile
 - Business Objects reports
 - Local Supervisory Review Instrument
 - MD CHESSIE completion reports
 - SAFE- C
 - MFRA
 - SSA'S Child Welfare Results Report
 - Family Centered Practice data
- State/national data
- Case records
- Stakeholder and consumer focus groups/interviews
- Shadowing of workers/supervisors
- Other sources

⁵ For example, if an LDSS is doing well in reunification of children under the age of 10, but doing poorly in reunifying older children, it may be appropriate to classify reunification for children under 10 as a strength but as an ANI for children over 10. Of course, it will be important to understand the causes of the differences between outcomes for different sub-groups.

Targeted Quality Assessment Review

The Targeted Quality Assessment (QA) Review will be led by DHR/SSA QA staff after receipt and approval of the QAR⁶. The primary goal of this review is to help further identify and clarify possible underlying causes for the trends and performance issues (both positive and negative) identified in the aggregate data and the QAR. Compliance to policies and positive outcomes will also be measured when needed, but aggregate data sources will be the primary source for these aspects of the CQI process whenever possible and appropriate.

Issues identified in the QAR (strengths, areas needing improvement, other areas as needed) will drive the selected populations/groups included in the Targeted QA Review. This review will be conducted in three phases:

Prior to the On-Site Review

1. MD CHESSIE case review by DHR/SSA QA staff, focusing on targeted questions/items.
2. Targeted data extractions/reports from MD CHESSIE to address specific issues, as needed.

On-Site Review

3. On-site case review, led by DHR/SSA QA staff, for review of items not able to be accessed via MD CHESSIE, as needed.
4. On-site interviews with relevant parties to the cases reviewed (child, parents, foster parents, caseworker, attorneys, collateral contacts, etc.).
5. On-site targeted stakeholder interviews, led by DHR/SSA QA staff.

After the On-Site Review

6. A final Targeted QA Report, prepared by DHR/SSA QA staff and provided to the LDSS.

The number of days needed for the on-site portion and the agenda for those days will be discussed during planning meetings/communications between DHR/SSA QA staff and the LDSS. The LDSS Director, Assistant Director(s), and other key leadership staff are expected to be present and available throughout the on-site review.

Volunteer Reviewers

It is the responsibility of the LDSS to recruit volunteer reviewers for the Targeted QA Review; volunteers should be a mix of community stakeholders and LDSS staff from other jurisdictions. DHR/SSA QA staff will provide an overview and training to volunteers through materials sent to volunteers prior to the review and on the first day. Volunteers will also be required to sign a confidentiality agreement (to be developed).

Selection of Targeted Cases and Stakeholders for Review and Interviews *Policies and procedures currently under development.*

MD CHESSIE Case Review and Targeted Questions/Items

As MD CHESSIE is the official case record for all child welfare clients served by Maryland's LDSSs, the case review will be conducted in MD CHESSIE. This review will be conducted by DHR/SSA staff prior to the on-site portion of the Targeted Quality Assessment Review.

⁶ If there is a disapproval/request for changes of a QAR, the Targeted QA Review may still be able to proceed; such decisions will be made on a case-by-case basis by DHR/SSA after discussions with the LDSS.

Policies and procedures on specific case review questions/items are currently under development.

Targeted Data Extractions/ Reports

In some situations, there may be additional aggregate data from MD CHESSIE (or other sources, such as the Local Supervisory Review Instrument) that provides useful information during the Targeted QA Review. It is anticipated that such data collection/extraction would primarily be the responsibility of the DHR/SSA QA staff (e.g. in the case of data needed from MD CHESSIE), but in some situations it may be necessary to request data from the LDSS (e.g. for additional workforce data). Any data reviewed will be shared with the volunteer reviewers and the LDSS administration.

On-Site Case Review

Review of hard-copy case records will occur only if external documents not able to be stored in MD CHESSIE (e.g. psychiatric evaluations, court orders, school records, etc.) are relevant to the case review. This decision will be made by DHR/SSA; in many cases, the summary of these documents/events in MD CHESSIE may be sufficient for the purposes of the case review.

A review of hard-copy records *in lieu* of data required and/or able to be entered into MD CHESSIE will not occur.

Case-Related Interviews

Policies and procedures currently under development.

Targeted Stakeholder Interviews

Policies and procedures currently under development.

Targeted QA Report

Within two weeks of completing the Targeted QA Review, DHR/SSA QA staff will prepare and submit a report the LDSS regarding the findings of the review, and the finalized Areas Needing Improvement and Strengths. The LDSSs will have two weeks to contact DHR/SSA QA with any questions regarding the report.

The Continuous Quality Improvement Plan (CQI Plan)

Purpose of the CQI Plan

The Continuous Quality Improvement Plan (CQI Plan) is based on the QAR and the Targeted QA Review. The CQI Plan is a three year plan the LDSS will develop and implement to improve child welfare outcomes for children and families. The Primary Indicators should be the central focus of the CQI Plan, with special emphasis on child safety, permanency, and well-being outcomes. (Secondary indicators will also be tracked; addressing the primary indicators should also address the secondary indicators, but the LDSS is responsible for identifying which strategies will address each indicator. If no 'primary' strategy relates to a secondary indicator, then an additional strategy will have to be developed.)

Although the main focus of the CQI Plan is remediation of the ANIs, it will also include strategies to maintain and monitor areas of strength. The CQI Plan will follow the framework of the QAR, and identify specific strategies for each ANI. For each area of strength, the CQI Plan will indicate current and/or new strategies designed to maintain and further improve these outcomes. For both ANIs and strengths, current QAR indicators will be used whenever possible. Both long-term (three-year) and interim goals (every six months) will be established in the CQI Plan, to assist in ongoing assessment of progress.

Each LDSS will engage in the development, implementation, and monitoring of a Continuous Quality Improvement Plan, even if all areas are found to be strengths. In this instance, the local DSS and DHR would continue to monitor progress on areas of strength in order to maintain progress and to work towards even higher performance standards and better outcomes. Information gained in this process could also be used to assist other LDSSs in improving their performance and outcomes.

Description of the CQI Plan Process, Format, and Frequency

The CQI Plan is to be developed at the end of the QAR process, and should be designed to be successfully implemented within three years, at which time the LDSS will engage in an assessment of the CQI Plan, and then enter the next round of CQI evaluation. The CQI Plan will be monitored semi-annually.

Although there are no formal requirements regarding the development of the CQI Plan, this should begin during the QAR process: as the LDSS identifies ANIs and strengths, and receives feedback from local stakeholders, the LDSS should also begin to identify strategies to improve outcomes for children and families. Input from local stakeholders will be crucial to the successful design and implementation of the CQI Plan.

Approval of the CQI Plan by DHR/SSA is required; both DHR/SSA QA and Child Welfare Practice and Policy staff will review the CQI Plan for appropriateness, feasibility, and effectiveness of proposed interventions. Additionally, information contained in the CQI Plans regarding ANIs, strengths, and resource needs will be collected, compared and combined with other LDSSs, and used by DHR/SSA in planning future statewide initiatives and resource development.

Please see Appendix D for the CQI Plan template/format.

Timeline of the CQI Plan Development and Submission

The CQI Plan is due to DHR/SSA QA within 2 months of the LDSS receiving the Targeted QA Review report. LDSSs are encouraged, however, to begin developing their CQI Plan throughout the development of the QAR.

Required Elements of the CQI Plan

The CQI Plan is required to present strategies to improve outcomes and/or performance standards for each ANI, as well as strategies to maintain or improve strengths. Each strategy should include clear start dates and timelines for proposed strategies, as well as specific long-term (three-year) and interim (every six months) goals; DHR/SSA QA staff will be available to assist in the establishment of realistic and meaningful goals. Goals will be set in comparison to established baselines (when available). Adjustment of start dates and interim goals may be made during the CQI Monitoring process, with the approval of DHR/SSA QA.

For each indicator, the following information must be presented:

1. Indication if the ANI relates to Child Safety (if so, this must be considered a high priority by both the LDSS and DHR/SSA);
2. Identification of ongoing/new strategies designed to address/improve this area; and
3. Identification of measure(s) to be used to monitor progress (typically, this will be the indicator itself; in rare instances, it may be necessary to develop an additional measure).

Complete information for each ANI/strength should be presented on no more than one page per indicator (see Appendix D for CQI Plan template).

Strategies should be specific to special sub-groups within child welfare, especially for indicators in which there are significant discrepancies in outcomes/performance standards for different client populations. All strategies should be developmentally and culturally appropriate for the target population.

Strategies identified in the CQI Plan should be based on evidence-based research and best practices in child welfare, as well as the unique needs and strengths of the LDSS, the local child welfare system, and the community. Input from local stakeholders should be included in the CQI Plan, and may well come directly from the initial stakeholder focus groups held for the QAR (or perhaps as an outgrowth of those groups).

The CQI Plan should focus primarily on strategies the LDSS can implement with current resources.⁷ Additional strategies may entail commitments of local stakeholders to provide needed services, trainings, to continue to work on future improvements, to address policy-based and other barriers, etc. The LDSS is welcome to include un-funded strategies as possible, future interventions, but is responsible for crafting an appropriate CQI Plan that can be implemented in a timely manner *with current resources*. Technical assistance may be available from DHR/SSA, but is dependent on available resources and must be discussed w/ DHR/SSA staff before inclusion in the CQI Plan.

⁷ Peer learning within and between LDSSs may be a no/low-cost strategy that can address performance and outcome standards.

Prioritization of CQI Strategies

While it may be challenging at times to develop effective strategies with current resources, the more difficult task may be to prioritize proposed strategies. Strategies addressing poor performance and outcomes relating to child safety should be considered the highest priority, and all interventions should be designed to create the maximum (lasting) improvement in the shortest amount of time.

After safety-related strategies are prioritized, however, careful thought and consideration must be given to remaining ANIs and strategies. While this will primarily be the responsibility of the LDSS, DHR/SSA QA staff will be available for consultation. As a guideline, below are several questions/issues to consider when prioritizing strategies:

1. Will improving on outcome 'A' have any unintended, negative effect on outcome 'B'? If so, will this represent a true decline in outcomes for children and families, or will the 'negative' trend for outcome 'B' be acceptable? (For example, increasing the number of reunifications will likely cause a drop in adoptions, but taken together, they represent positive movement in the overall child welfare system.)
2. Is there capacity to equally improve on all indicators, or is it reasonable to expect only limited progress in some areas? What measure of 'limited progress' is acceptable (to the LDSS, to the community, to DHR/SSA)?
3. Given current resources (and expected future resources), what strategies provide the potential for the largest improvements? Which interventions have the potential to impact the largest number of children and families?
4. Are current strategies already addressing an ANI? If so, is an additional strategy needed, or will the current interventions bring about the desired change in the desired timeframe?

Brief Summary of CQI Plan Monitoring

Progress made on the CQI Plan will be reviewed every six months, and will include a report submitted by the LDSS and a conference call with DHR/SSA QA staff to review the report. A full description of the CQI Plan Monitoring process is presented later, after sections on the Local Supervisor Review, Local Supervisory Review – 2nd Level QA Review, and the Monthly QA Report on Required CHESIE Activities, as these are all included in the CQI Plan Monitoring process.

Local Supervisory Review

Please refer to Policy Directive SSA 09-17 (3/10/09) for instructions and information on the Local Supervisory Review itself.

Please note that low scores on the LSRI may indicate a need for additional training and/or coaching for a supervisor's staff; LDSS administrators are responsible for monitoring LSRI data and implementing corrective action as needed (please contact DHR/SSA if additional support or guidance is needed).

Currently, LDSSs are also required to submit a quarterly report to DHR/SSA QA staff to assist in the tracking of assigned and completed LSRI and alternate LSRI. This report may later be eliminated once an automatic LSRI assignment function is created in MD CHESSIE. LDSSs will be informed if/when this report is no longer required. Please see Appendix K for a template of this report.

Local Supervisory Review Instrument – 2nd Level QA Review

Purpose and Overview of the Local Supervisory Review – 2nd Level QA Review

The Local Supervisor Review Instrument (LSRI) is an important element in both the delivery of child welfare services in the field and in LDSS/DHR administrations' understanding of the dynamics of casework practice at the worker level. Therefore, it is important to ensure that the instrument itself is being used consistent with DHR policies and training. To achieve this, an LSRI – 2nd Level QA Review process will be used.

Due to the inherent importance of the supervisor-supervisee relationship in the LSR process, it would be impossible to fully recreate the circumstances that led to the supervisor's ratings of each item in the LSRI. What is available, however, is MD CHESSIE (i.e. case documentation) that could either support or not support a supervisor's rating. Therefore, the LSRI – 2nd Level QA Review will utilize MD CHESSIE to assess whether or not there is evidence to support the supervisor's rating of each item in an LSRI.

Correlation Rate

A correlation rate for each LDSS of 75% of items reviewed is expected. That is, of all items in the LSRI reviewed by DHR/SSA QA staff during the LSRI – 2nd Level QA Review process, it is expected that at least 75% of the items are found to have MD CHESSIE documentation which supports the supervisor's ratings. For example, in the Investigations module of the LSRI, item 1 is "the caseworker saw the child within 24 hours of accepting a report of suspected child abuse or 5 days of accepting a report of suspected neglect." If the supervisor gave a rating of "yes," DHR/SSA staff will be looking to verify that the contact log shows that, in fact, the child was seen in the appropriate timeframe.

Rates 75% and above would indicate that both the supervisor's ratings are consistent with the LSRI policy and that sufficient MD CHESSIE documentation exists to support those ratings.

Correlation rates below 75% can indicate one of two issues (or both):

1. Supervisors are not using the LSRI rating scales consistent with DHR policy and training.

2. Workers are not sufficiently documenting case activities in MD CHESSIE, and therefore documentation does not exist that supports the appropriateness of the supervisors' ratings.

It will be impossible for DHR/SSA QA staff to differentiate which of the two causes lies behind a sub-standard correlation rate. It will be the responsibility of the LDSS administration to make this determination. Use of additional data regarding data entry (Business Objects reports on AFCARS and NCANDS data entry, DHR/SSA QA Monthly Report on Required MD CHESSIE Elements, etc.) and case reviews can provide additional information to the LDSS administrators.

Both potential causes of low correlation rates are important and concerning issues, and must be addressed by the LDSS. Additional training in the LSRI and/or MD CHESSIE may be available if needed.

Description of the Local Supervisory Review Instrument (LSRI) – 2nd Level QA Review Process, Format, and Frequency

The LSRI – 2nd Level QA Reviews will be completed by DHR/SSA QA staff on a random sample of LSRI's completed by the LDSS during a six-month time period. The sample will be the larger of either 10% of the LSRI's assigned to an LDSS during the six-month period, or five LSRI's.

The sample will be pulled from the LSRI's assigned to the LDSS in the first six months of the preceding seven month period; this one-month 'lag' will ensure that inconsistent ratings will not be due to insufficient time for workers to complete data entry in MD CHESSIE. Incomplete LSRI's selected for the random sample may be substituted by DHR/SSA QA staff with completed LSRI's, but the number of incomplete LSRI's will be included in the LSRI – 2nd Level QA Review report, as this indicates a lack of compliance to the LSRI policy.

Procedures and Timeline of the Local Supervisory Review – 2nd Level QA Review

The LSRI – 2nd Level QA Review will be conducted at least every six months for each LDSS; a formal DHR/SSA QA LSRI – 2nd Level QA Review Report will be included with that month's Monthly QA Report of Required MD CHESSIE Activities. The LDSS is responsible for analyzing this data, presenting it as part of their semi-annual CQI Plan Monitoring Report/presentation, and addressing any problems or issues found through these reviews (including both supervisor non-adherence to the LSRI policies and worker issues highlighted in original LSRI ratings).

Process

For each individual case of the LSRI – 2nd Level QA Review sample, DHR/SSA QA staff will review the supervisor's ratings for each item of the LSRI, using MD CHESSIE documentation (contact logs, service plans, safety and risk assessments, etc.) to determine if documentation supports the supervisor's ratings for the sample case. The DHR/SSA QA staff will assign ratings of "yes" or "no" depending on whether or not the MD CHESSIE documentation supported the supervisor's rating for that item.

After the completion of the sample cases, the total number of items (for all LSRI's in the LDSS's sample) rated as "yes" (i.e. showing MD CHESSIE documentation that supports the supervisor's LSRI rating) will be divided by the total number of items reviewed during the LSRI-2nd Level QA Review. A correlation of

75% of items rated as “yes” will be required to consider the LDSS to be in compliance with use of the LSRI.

Correlation Rates Below 75%

Scores below 75% will trigger an automatic, additional LSRI – 2nd Level QA Review by the DHR/SSA QA supervisor (or designee). The purpose of this additional review is to verify the first LSRI – 2nd Level QA Review results prior to presenting a non-compliance result to an LDSS.

The number of sample cases reviewed in this additional review will be as follows:

- If the sample size was 5 LSRI, all 5 will be re-reviewed
- If the sample size was between 6 -10, a random set of 5 will be reviewed
- If the sample size was greater than 10, a random set of 50% will be reviewed

If the original DHR/SSA QA LSRI – 2nd Level QA Review and the re-review correlation rate are within 10% of each other, the higher of the two rates will be the final rate for the LDSS.

If the original DHR/SSA QA LSRI – 2nd Level QA Review and the re-review correlation rate are different by more than 10%, the DHR/SSA QA manager (or designee) will conduct a third and final LSRI – 2nd Level QA Review, and these results will be used as the final results.

Required Elements of the Local Supervisory Review – 2nd Level QA Review

The *DHR/SSA QA LSRI – 2nd Level QA Review Report* will be prepared by DHR/SSA QA staff, and will include the total numbers of random cases reviewed, the number of items reviewed, and the correlation rate. Additionally, client/case IDs of LSRI cases reviewed will be provided. (See Appendix E for report template.)

The LDSS is required to include data from this report in the CQI Plan Monitoring Report/presentation, and to take appropriate corrective actions if the LDSS is found to not be in compliance.

Monthly Quality Assurance Report on Required MD CHESSIE Elements

Purpose of the Monthly QA Report on Required MD CHESSIE Elements

The *Monthly QA Report on Required MD CHESSIE Elements* tracks LDSS data entry completion and compliance in completing required data fields. This report should be used by the LDSS administration to identify and correct any non-compliance in MD CHESSIE data entry, and will be used by DHR/SSA to monitor each LDSS's compliance to data entry policies.

Description of the Monthly QA Report on Required MD CHESSIE Elements Process, Format, and Frequency

The Monthly QA Report on Required MD CHESSIE Elements will be prepared by DHR/SSA QA staff, and submitted to the LDSS, using aggregate data from MD CHESSIE. Completion rates will be provided for:

- AFCARS data elements
- NCANDS data elements
- SAFE-C assessments
- MFRA assessments
- LSRIs
- Well-being data elements
 - *OOH placements - medical examination within 10 days of entry*
 - *OOH placements –with comprehensive assessment within 60 days of entry*
 - *OOH placements –enrolled in school*
 - *OOH placements - with no psychiatric hospitalization during the year*
- Additional information to be included:
 - Clients with no caseworker contact in over 30 days
 - Child Placing Agency/Independent Living Program (CPA/ILP) placement data entry
 - Other data fields and assessments/reviews as needed

Additional data on incomplete data entry will be taken from State Stat Exception Reports.

Procedures and Timeline of the Monthly QA Report on Required MD CHESSIE Elements

Each month, DHR/SSA QA staff will prepare and send the Monthly QA Report on Required MD CHESSIE Elements report to the LDSS, by the end of the month. The report will be based on completion data from the prior month.

Required Elements of the Monthly QA Report on Required MD CHESSIE Elements

See Appendix F for a template of the report. This report will contain only aggregate data (total number of cases for each area), and completion rates. The LDSS can access case-specific information in other reports available through Business Objects and SSA's State Stat Exception Reports, distributed through the Research/ Evaluation/ Systems Development/ Training unit (RESDT). The LDSS is responsible for analyzing data contained in the report, including this data in semi-annual CQI Plan Monitoring Reports/presentations, and implementing corrective action for MD CHESSIE data entry non-compliance.

Continuous Quality Improvement Plan Monitoring

Purpose of the Continuous Quality Improvement Plan Monitoring

Each LDSS will develop and implement a Continuous Quality Improvement Plan (CQI Plan), designed to address Areas Needing Improvement (ANIs) and to continue progress in areas of strength, as identified in the QAR and the Targeted QA Review. The CQI Plan Monitoring process will be a collaborative process between the LDSS and DHR/SSA to:

- Track progress on the CQI Plan implementation, LSRI, LSRI – 2nd Level QA Review, and the QA Report on Required MD CHESSE Elements, and other child welfare indicators/outcomes;
- Analyze data on the CQI Plan indicators; and
- Coordinate technical assistance as needed.

Description of the Continuous Quality Improvement Plan Monitoring Process, Format, and Frequency

CQI Plan Monitoring will be conducted through written reports, submitted by the LDSS to DHR/SSA QA, and conference calls with DHR/SSA QA and other DHR/SSA staff. During the conference call, the LDSS will be required to present a summary of the written report, and the LDSS and DHR/SSA staff will discuss the progress and make additional plans to address any ongoing issues. The written report will be due semi-annually (every six months), and will be the basis of the LDSS presentation and conference call. The presentation should be a summary of progress made to date, using tables, graphs, and charts to present data (using PowerPoint).

DHR/SSA QA staff will send updated data and data analysis to the LDSS approximately one month prior to the semi-annual report due date. This report will contain data on all primary and secondary indicators (as available from MD CHESSE, and excluding data on auxiliary services, workforce issues and systemic factors; this data will be provided by the LDSS).

The LDSS will be responsible for submitting written reports with updated analysis of this data, including analysis of positive and negative trends (see Appendix D). Data should be presented in tables, graphs, or charts, with narrative sections kept to a minimum. During conference calls, LDSS staff should be prepared to discuss data analysis, challenges, and successes during each conference call, with appropriate administrators and other staff participating. (Face-to-face meetings at DHR/SSA headquarters in Baltimore may be held in place of conference calls, if requested by the LDSS.)

Procedures and Timeline of the Continuous Quality Improvement Plan Monitoring

Semi-annual reports will be due every six months after the approval of the CQI Plan, on dates determined at that time by DHR/SSA QA. Conference calls (with LDSS presentations) will occur approximately one week after the report due date.

Required Elements of the Continuous Quality Improvement Plan Quarterly Report

The CQI Plan Quarterly Report must contain data on the following elements (see Appendix D):

- for each Area Needing Improvement, updated data and summary of progress on CQI Plan implementation strategies;
- updated data on selected areas of strength (to be determined by DHR/SSA QA and the LDSS);
- completion rates and findings of the LSRI and the LSRI – 2nd Level QA Review;
- analysis of findings based on the QA Report on Required MD CHESSIE Elements; and
- other child welfare indicators/outcomes, as appropriate.

Coordination of Technical Assistance

Just as in the development of the CQI Plan, DHR/SSA Child Welfare Practice and Policy staff will be consulted with on issues regarding selection and implementation of strategies and will provide technical assistance when possible (dependent on available resources). Additionally, LDSSs in need of more specialized technical assistance may be able to access the National Resource Centers and other state or national experts; the LDSS should consult with DHR/SSA QA staff about this possibility as needed.

Implementation of New CQI Processes Prior to an LDSS's QAR/CQI Plan

As approximately only eight LDSSs will go through the entire QAR/CQI Plan development process every fiscal year, the following describes the process all LDSSs will follow until their QAR is held:

1. The LDSS will receive the Monthly Report on Required MD CHESSE Elements reports;
2. The LDSS will receive semi-annual data from DHR/SSA regarding progress made on each of the primary indicators;
3. DHR/SSA QA staff will conduct the LSRI – 2nd Level QA Review for the LDSS, and send the corresponding report to the LDSS; and
4. The LDSS will submit a semi-annual report to DHR/SSA QA regarding progress made on the primary indicators, data from the LSRI and the LSRI - 2nd Level QA Review, and data included in the Monthly Report on Required MD CHESSE Elements.
5. The LDSS will engage in the semi-annual conference calls with DHR/SSA QA staff regarding the semi-annual report.
6. The first semi-annual report submitted must include data updates, strategy updates, and other follow-up information based on the LDSS's previous Program Improvement Plan (PIP). During the LDSS's first conference call, DHR/SSA and LDSS staff will discuss the LDSS's previous PIP, and determine which goals/indicators to continue until the LDSS's QAR/CQI Plan development. (LDSSs will be informed of the due date of their first semi-annual report.)

In essence, the LDSS will engage in the on-going CQI mechanisms, including tracking data, implementing needed changes, and providing updates and data analysis. Although not every LDSS will have gone through the QAR/CQI Plan development process, each will be expected to implement needed corrective actions and/or strategies to address poor outcomes or performance data. Technical assistance will be available from DHR/SSA (depending on available resources).

Appendix A – Timeline of QAR and CQI Processes

Quality Assessment Review (QAR) (2 months)		
Activity	Timeline	Primary Responsible Party
Initiation of CQI Process <ul style="list-style-type: none"> • DHR/SSA QA staff will send notification of initiation to LDSS staff • Notification will contain data and data analysis of CQI indicators 	Week 1	DHR/SSA QA
Coordination Meeting <ul style="list-style-type: none"> • DHR/SSA & LDSS staff to participate • Meeting can be held in person or via conference call • Topics to discuss include deadlines, dates for on-site review, technical assistance needs, etc. 	Week 1- 2	LDSS and DHR/SSA QA
Development of the Quality Assessment Review (QAR) <ul style="list-style-type: none"> • LDSS to review and analyze data provided by DHR/SSA (analysis to contain the ‘story behind the data’) • LDSS to hold and lead stakeholder focus groups • LDSS to prepare and submit QAR, with preliminary identification of areas of strength and areas needing improvement (ANIs) • LDSS to recruit volunteer reviewers for On-Site review (volunteers should be from the community and other LDSSs) 	Weeks 1 – 6 <i>QAR due at end of Week 6</i>	LDSS
DHR/SSA Review of QAR <ul style="list-style-type: none"> • DHR/SSA QA and CW Practice & Policy staff to review QAR • DHR/SSA QA to approve or request revisions⁸ (and provide technical assistance needed) 	Weeks 7 – 8 <i>Approval or disapproval due at end of Week 8</i>	DHR/SSA QA

⁸ If DHR/SSA is unable to approve QAR due to discrepancies in identification and explanation of ANIs and/or strengths, (or for other similar issues), DHR/SSA will determine if CQI procedure can continue, using populations/groups identified by DHR/SSA and/or LDSS as groups needing further review (i.e. Targeted QA Review).

Targeted QA Review (2 months)		
Activity	Timeline	Primary Responsible Party
DHR Preparation for Targeted QA Review <ul style="list-style-type: none"> DHR/SSA QA will notify LDSS of targeted groups for case reviews and stakeholder interviews DHR/SSA QA will notify LDSS of specific cases to be reviewed, including which cases should be scheduled for case-related interviews 	Week 1	LDSS and DHR/SSA QA
LDSS Preparation for Targeted QA Review <ul style="list-style-type: none"> LDSS will schedule case-related interviews and targeted stakeholder interviews 	Week 1 - 2	
Targeted Case Review and Data Extraction, using MD CHESSIE <ul style="list-style-type: none"> DHR/SSA QA staff will begin reviewing selected cases, via MD CHESSIE, using targeted case review questions (see Appendix H) DHR/SSA QA staff will begin reviewing selected data reports from MD CHESSIE (as needed) 	Week 3	DHR/SSA QA
On-Site Review – Targeted Case Review and Stakeholder Interviews <ul style="list-style-type: none"> DHR/SSA QA staff will lead On-Site review, including case reviews (as needed), case-related interviews, and targeted stakeholder interviews⁹ 	Week 4	LDSS and DHR/SSA QA
Report on Findings from Targeted QA Review <ul style="list-style-type: none"> Prepared by DHR/SSA QA and submitted to LDSS Report will include finalized ANIs and strengths (based on QAR and Targeted QA Review) 	Week 5- 6	DHR/SSA QA
LDSS Opportunity to Review the Targeted QA Review Report <ul style="list-style-type: none"> LDSS to contact DHR/SSA QA staff by the end of Week 8 with any questions about the report and/or findings 	Weeks 7 - 8	LDSS

⁹ DHR SSA/QA staff will provide orientation/training to volunteer reviewers on the first day of the on-site review.

Continuous Quality Improvement Plan Development (2 months)		
Activity	Timeline	Primary Responsible Party
LDSS Development and Submission of the Quality Continuous Improvement Plan <ul style="list-style-type: none"> Developed by LDSS, based on QAR and Targeted QA Review Report Must address all ANIs and strengths as identified in the Targeted QA Review Report 	Weeks 1 – 8 <i>Report due to DHR/SSA by the end of the 8th week</i>	LDSS

Continuous Quality Improvement Plan Review (1 month)		
Activity	Timeline	Primary Responsible Party
DHR/SSA Review of the CQI Plan <ul style="list-style-type: none"> DHR/SSA QA and CW Practice & Policy staff to review CQI Plan DHR/SSA QA to approve or request revisions (and provide technical assistance as needed) 	Weeks 1- 4 <i>Approval or disapproval due at end of Week 10</i>	DHR/SSA QA

Continuous Quality Improvement Plan Implementation (3 years)		
Activity	Timeline	Primary Responsible Party
Implementation of CQI Plan	Immediately upon receipt of approval of CQI Plan	LDSS

CQI Plan Monitoring		
Activity	Timeline	Primary Responsible Party
LSRI <ul style="list-style-type: none"> LDSS to complete monthly LSRI 	Monthly	LDSS and DHR/SSA QA
Monthly Report on Required MD CHESSIE Elements <ul style="list-style-type: none"> DHR/SSA QA staff to send monthly report to LDSS regarding required MD CHESSIE elements; LDSS is expected to take immediate corrective action for non-compliance to MD CHESSIE requirements 	Monthly	LDSS and DHR/SSA QA
LSRI 2nd Level QA Review <ul style="list-style-type: none"> DHR/SSA QA staff to conduct 2nd Level QA Review of LSRI completed in the first six months out of the previous seven month period DHR/SSA QA staff to send report to LDSS with findings <p><i>Report to be sent to LDSS approximately 1 month prior to CQI monitoring report due date/conference call</i></p>	Beginning on the 5 th month after CQI implementation date, and then every six months	DHR/SSA QA
CQI Monitoring <ul style="list-style-type: none"> LDSS to submit CQI Monitoring Report to DHR/SSA QA (report to include data on CQI Plan, LSRI data, LSRI 2nd Level QA Results, Monthly Report on MD CHESSIE Required Elements, and plans to address any issues noted in these reports) Conference call with LDSS and DHR/SSA QA to review data, discuss progress on implementation of strategies, revise goals/strategies as needed, and coordinate technical assistance when appropriate 	Every six months, after CQI implementation date	LDSS and DHR/SSA QA
Completion of CQI Plan and initiation of new QAR <ul style="list-style-type: none"> LDSS and DHR/SSA to review progress made on CQI Plan and assess if investments made in strategies resulted in increased child welfare practice fidelity, improved outcomes, or other effects LDSS to submit summary report to DHR/SSA 	Year 3	LDSS and DHR/SSA QA

Appendix B - Required Elements of the Quality Assessment Review

Notes:

- *The “story behind the data” should include contextual information, causes of (positive and negative) trends, the meaning and significance of the data, and the probable consequences of data trends.¹⁰ This analysis of the underlying dynamics of data trends depends on the unique circumstances of the jurisdiction, the LDSS, and the child welfare client population.*
 - *All data presented should be by State Fiscal Year quarter when available.*
 - *All data presented should be broken down by client age, race, gender, and other relevant characteristics when possible.*
 - *Data from the Child and Adolescent Need and Strengths (CANS) assessment will be required once fully implemented for each program area.*
 - *Data and measures based on DHR’s supervision model will be required and incorporated once available.*
1. LDSS stakeholder focus/workgroups – The LDSS is required to hold one or more stakeholder focus and/or workgroup, to engage the community in identifying the department’s areas of strength and areas needing improvement, and to identify the causes for both.
 - a. Stakeholders that must be included in this process are:
 - i. Parents/legal guardians of children being served (or who have been served) by the LDSS
 - ii. Children/youth being served (or who have been served) by the LDSS
 - iii. Attorneys
 - iv. Judges
 - v. Sister agencies (LMB, DHMH – CSA and DDA, local school system, and DJS)
 - vi. Public and private foster care providers (foster parents, group home providers, CPA agencies, etc.)
 - vii. Other service providers
 - viii. Other community members
 - ix. *Note - If an LDSS is unsuccessful in engaging these stakeholders in focus and/or workgroups, the LDSS should consult with the designated DHR QA staff. In some instances, key informant interviews may be used in place of the group meetings, but only with the prior written approval of the DHR QA staff.*
 2. QAR Report – The LDSS is required to submit a QAR Report; this report is a self-assessment of the LDSS. This report must be submitted electronically, and must contain the following elements:
 - a. Brief description of the jurisdiction and communities/populations served by the DHR, including a brief analysis of population data, economic data, educational attainment data, crime data, assessment of local resources, and other relevant factors.

¹⁰ For example, if an LDSS is found to have decreasing numbers of reunifications: the context may be changes in the jurisdiction’s overall population, resources, judicial preferences, etc.; the causes may be decreases in the overall OOH population, an increase in severe child abuse/neglect cases that result in TPR, lack of resources to support family success at reunification, etc; the meaning/significance may be that more children are suffering from more severe incidents of abuse/neglect; the consequences may be an increase in the number of children in care, increase lengths of stay, increase in adoptions, etc.

- b. Summary of the LDSS - including a summary of required and auxiliary child welfare services provided, the LDSS's internal QA/CQI process, workforce, and other issues.
- c. A brief summary of the stakeholder focus/workgroups, including the key strengths, areas needing improvement, and causes identified. An appendix should be included containing the dates of the focus/workgroups and corresponding lists of participants (including their role in the child welfare system).
- d. Results of CRBC reviews
 - i. Key areas of strengths of LDSS identified
 - ii. Key areas needing improvement (ANIs) of LDSS identified
 - iii. Causes of strengths/ANIs identified
- e. Results of Local Supervisory Review Instruments
- f. Results of Monthly Reports of MD CHESSIE Required Elements
- g. Primary Indicators - Data and full analysis of the LDSS's child welfare primary indicator data (data to be provided by DHR/SSA; analysis to be provided by LDSSs):
 - i. Safety Measures
 - 1. *Likelihood of maltreatment (incidence rate per 1,000 children)*
 - a. *In the general population*
 - b. *During in-home services*
 - c. *During foster care*
 - 2. *Likelihood of maltreatment recurrence*
 - ii. Permanency Measures
 - 1. *Likelihood of placement (incidence rate per 1,000 children)*
 - 2. *Likelihood of permanency and the timing of the exit (adoption, reunification & guardianship together)*
 - 3. *Likelihood of nonpermanent exit and the timing of those exits (e.g. Runaway)*
 - 4. *Likelihood of reentry and the timing of the reentry*
 - 5. *Placement stability and the timing of the moves relative to entry & exit*
 - iii. Well-Being Measures- Health, Education, and Mental Health
 - 1. *The percentage of children entering OOH placements who have been examined by a medical provider within 10 days of entry into the OOH placement.*
 - 2. *The percentage of children in OOH placement who received a comprehensive assessment in compliance with federal regulations for early and periodic screening, diagnosis, and treatment program within 60 days of entering OOHO placement.*
 - 3. *The percentage of school-aged children in OOH placement enrolled in school.*
 - 4. *The percentage of children in OOH placements who did not experience a psychiatric hospitalization.*
 - iv. Place Matters Measures¹¹
 - 1. *Number of children in Out-of-Home Placement*
 - 2. *Percentage of children in Group Homes*
 - 3. *Percentage of children in Family Foster Homes*
 - 4. *Adoptions*

¹¹ Specific Place Matters measures also address areas of child safety, permanency, and well-being, but are separated here to highlight the specific goals of this initiative.

5. *Children placed in their home jurisdiction*
 - a. *Family Foster Homes*
 - b. *Group Homes*
- v. *Selected CFSR Measures*¹²
 1. *Timeliness of reunification*
 - a. *C1.3 – Of all children who entered foster care for the first time in the 6-month period just prior to the year shown, and who remained in foster care for 8 days or longer, what percent were discharged from foster care to reunification in less than 12 months from the date of latest removal from home?*
 - b. *C1.4 – Of all children who were discharged from foster care to reunification in the 12-month period prior to the year shown, what percent re-entered foster care in less than 12 months from the date of discharge?*
 2. *Timeliness of adoptions of children discharged from foster care*
 - a. *C2.3: Of all children who were in foster care on the first day of the year shown, and who were in foster care for 17 continuous months or longer, what percent were discharged from foster care to a finalized adoption by the last day of the year shown? The denominator for this measure excludes children who, by the end of the year shown, were discharged from foster care with a discharge reason of live with relative, reunification, or guardianship.*
 - b. *C2.4: Of all children who were in foster care on the first day of the year shown for 17 continuous months or longer, and who were not legally free for adoption prior to that day, what percent became legally free for adoption during the first 6 months of the year shown? (Legally free means that there was a parental rights termination date reported to AFCARS for both mother and father.) The denominator for this measure excludes children who, by the last day of the first 6 months of the year shown, were not legally free, but had been discharged from foster care with a discharge reason of live with relative, reunification, or guardianship.*
 - c. *C2.5: Of all children who became legally free for adoption during the year shown (i.e., there was a parental rights termination date reported to AFCARS for both mother and father), what percent were discharged from foster care to a finalized adoption in less than 12 months of becoming legally free?*
 - d. *C3.1: Of all children who were in foster care for 24 months or longer on the first day of the year shown, what percent were discharged to a permanent home prior to their 18th birthday and by the end of the fiscal year? A child is considered discharged to*

¹² These CFSR measures were recommended by Chapin Hall as appropriate for use in the CQI context (*Child and Family Services Review Indicators from a CQI Perspective*, Chapin Hall at the University of Chicago, unpublished document, distributed 2009).

a permanent home if the discharge reason is adoption, guardianship, reunification, or live with relative.

- vi. *Fidelity to Maryland Child Welfare Practice Model Measures*¹³
 - 1. *AFCARS data completion rates*
 - 2. *NCANDS data completion rates*
 - 3. *SAFE-C completion rates*
 - 4. *MFRA completion rates*
 - 5. *Timeliness of investigations*
 - a. *Timeliness of investigations for reports of abuse (i.e. percentage of investigations in which the child is seen within 24 hours)*
 - b. *Timeliness of investigations for reports of neglect (i.e. percentage of Investigations in which the child is seen within 5 days)*
 - 6. *Percent of children/caregivers seen every 30 days – in-home and OOH*
 - 7. *Family Centered Practice measures (to be developed)*
 - a. *Percentage of cases which had FIMs in accordance with policies*
 - 8. *Others to be identified, as needed*
- b. Secondary indicators - Data and full analysis of the LDSS's child welfare secondary indicator data (data to be provided by DHR/SSA; analysis to be provided by LDSSs):
 - i. Investigations
 - 1. How much did we do?
 - a. Number of referrals
 - b. Number of screened in and screened out referrals
 - c. Number of investigations
 - d. Number of allegations by type (physical abuse, sexual abuse, neglect, mental injury neglect, total)
 - e. Number of investigations resulting in findings of:
 - i. Indicated
 - ii. Unsubstantiated
 - iii. Ruled out
 - f. Number of victims of indicated abuse or neglect
 - g. Number of victims of indicated abuse or neglect removed from the home
 - h. Number of victims of indicated abuse or neglect who remained in the home
 - 2. How well did we do it?
 - a. Percentage of screened out reports of child abuse or neglect that are documented as reviewed by a supervisor [§5-1303 (2)]
 - b. The percentage of CPS investigations that are initiated in accordance w/ §5-706 [§5-1303 (4)]:
 - i. Within 24 hours after receiving a report of suspected physical or sexual abuse
 - ii. within 5 days after receiving a report of suspected neglect or suspected mental injury of a child

¹³ 95% adherence to Maryland's child welfare practice model is expected for fidelity measures.

- c. The percentage of CPS investigations that are completed in accordance w/ §5-706 [§5-1303 (4)]:
 - i. Completed within 60 days
 - d. For all indicated and substantiated cases of abuse and neglect, the percentage of children who [§5-1303 (5)]:
 - i. Received family preservation services
 - ii. Are able to remain safely in their own home for 18 months after receiving family preservation services
 - e. Completion rate of SAFE-C
 - f. Completion rate of MFRA
 - 3. Is anyone better off?
 - a. Recurrence within 12 months of child abuse or neglect among victims of indicated abuse or neglect [§5-1303 (1)]
 - b. Recurrence within 6 months of child abuse or neglect among victims of indicated abuse or neglect (StateStat/Place Matters)
 - c. The incidence of child abuse or neglect for a child who, in the prior 12 months, was not removed from the home following an investigation that found indicated or unsubstantiated abuse or neglect [§5-1303 (3)]
 - 4. Story behind the data
 - 5. Identification of each indicator as a strength and area needing improvement
- ii. In-Home Services
 - 1. How much did we do?
 - a. Numbers of children and families served
 - 2. How well did we do it?
 - a. To be determined – measures of fidelity to Family Centered Practice
 - b. SAFE-C completion data
 - c. MFRA completion data
 - d. Average number of face-to-face contact per family, per week (program down by specific in-home service categories?)
 - 3. Is anyone better off?
 - a. Children with no indicated maltreatment during in-home services (and up to 6 months/1 year after?)
 - b. Children with no OOH placement during in-home services (and up to 6 months/1 year after?)
 - c. Children who are able to safely remain in the home 18 months after receiving Family Preservation Services (5-1302)
 - d. MFRA data
 - 4. Story behind the data
 - 5. Identification of each indicator as a strength and area needing improvement
- iii. Out of Home Services
 - 1. How much did we do?
 - a. The number of children in OOH placement (State Stat/Place Matters)

- i. Number & percentage of children in Group Homes (State Stat/Place Matters)
 - ii. Number & percentage of children in Family Homes (State Stat/Place Matters)
 - b. The percentage of children in an OOH placement living in [§5-1304 (5)]:
 - i. Kinship care homes
 - ii. Restricted foster homes
 - iii. Regular foster homes
 - iv. Treatment foster homes
 - v. Group homes
 - vi. RTCs
 - vii. Other specified types of placements
 - c. Number of VPA placements (and percentage of total OOH), and
 - i. Time-limited (number)
 - ii. Disability (number)
- 2. How well did we do it?
 - a. The percentage of children who exit foster care within time periods consistent with federal national standards with a breakdown by each standard [§5-1305 (1)]
 - i. Exits to reunification in less than 12 months (number & percentage)
 - ii. Exits to reunification, median stay (in months)
 - iii. Entry cohort reunification in less than 12 months (number & percentage)
 - b. The percentage of children in OOH who have siblings living in different placements (5-1305 3)
 - c. The percentage of children with two or more OOH placements during a report year [§5-1305 (2)]
 - d. Two or fewer placement settings for children in care less than 12 months (Federal measure)
 - e. Two or fewer placement settings for children in care for 12 to 24 months (Federal measure)
 - f. Two or fewer placement settings for children in care for 24+ months (Federal measure)
 - g. the percentage of children in out-of-home placements who received a comprehensive assessment in compliance with federal regulations for the early and periodic screening, diagnosis, and treatment program within 60 days of entering out-of-home placement [§5-1306 (1)]
 - h. the percentage of eligible children entering foster care or kinship care who [§5-1306 (2)]:
 - i. Have been examined by a medical providers within 10 days of entry into the OOH placement
 - ii. Have a designated health care providers within 10 days of entry into the OOH placement
 - i. The percentage of school-aged children in OOH placements enrolled in school [§5-1306 (3)]

- j. Average LOS, by OOH type and also VPA type
 - k. The number and percentages of children placed in their home jurisdiction (for children placed in Family Foster Homes and Group Homes) (StateStat/Place Matters)
 - l. Exits to permanency prior to 18th birthday for children in care for 24+ months (Federal measure)
 - m. Exits to permanency for children with TPR (Federal measure)
 - n. Children emancipated who were in foster care for 3 years or more (Federal measure)
 - o. SAFE-C completion rate
 - p. MFRA completion rate
3. Is anyone better off?
 - a. The incidence of indicated or unsubstantiated findings of child abuse or neglect within 12 months following the release of the child committed to the Department [§5-1304 (2)]
 - b. The percentage of children who exit foster care and are [§5-1305 (4)]:
 - i. Reunified with a parent or guardian
 - ii. Placed with a relative who is awarded custody and guardianship
 - iii. Adopted
 - iv. Placed with a nonrelated guardian
 - v. (also provide total number of exits, and numbers of above)
 - c. The number and percentage of children exiting foster care due to aging out
 - d. The number of children who are recommitted to the Department within 12 months of release from commitment to the Department [§5-1305 (8), and Federal measure]
 4. Story behind the data
 5. Identification of each indicator as a strength and area needing improvement
- iv. Adoptions
1. How much did we do?
 - a. Number of legally free children
 - b. Number of children exiting custody to a finalized adoption
 - c.
 2. How well did we do it?
 - a. Number of legally free children with a plan of adoption
 - b. Percentage of all legally free children exiting to a finalized adoption
 - c. Average length of time in care for children with a plan of adoption
 - d. Average length of time in care since TPR
 - e. Exits to adoption, median length of stay (Federal measure)
 - f. Children in care 17+ months, adopted by the end of the year (Federal measure)

- g. Children in care 17+ months achieving legal freedom within 6 months (Federal measure)
- h. Number of children placed in finalized adoptions with their siblings
- 3. Is anyone better off?
 - a. Exits to adoption in less than 24 months (Federal measure)
 - b. Number and percentage of children adopted who reenter foster care
 - c. Legally free children adopted in less than 12 months (Federal measure)
- 4. Story behind the data
- 5. Identification of each indicator as a strength and area needing improvement
- v. Resource Homes
 - 1. How much did we do?
 - a. The number of foster homes and treatment foster homes available for children in the custody of a local department [§5-1305 (6)]:
 - i. the # of foster homes and treatment foster homes licensed by the LDSS
 - ii. the # of foster homes and treatment foster homes licensed by ALL LDSSs
 - b. The number and percentages of unrestricted and restricted foster homes
 - 2. How well did we do it?
 - a. The percentage of foster homes and kinship care homes in which the following have been conducted according to regulation [§5-1305 (7)]:
 - i. Required criminal background checks
 - ii. Fire and safety inspections
 - iii. Health and safety checks
 - iv. Reconsiderations, as applicable
 - v. Any other safety measures adopted by regulation
 - 3. Is anyone better off?
 - a. Incidence of indicated or unsubstantiated findings of child abuse or neglect of children in DSS custody for placements in [§5-1304 (1)]:
 - i. Foster care homes
 - ii. Kinship care homes
 - iii. RTC
 - iv. Group Homes
 - v. With family members
 - vi. Other forms of substitute care
 - 4. Story behind the data
 - 5. Identification of each indicator as a strength and area needing improvement

- vi. Auxiliary Services - Other CW Related Services/Requests of Other Agencies, such as Child of Minor Parent, ICPC Incoming, Parent/Guardian of Child in OOH, ROA, VP Requests for Services, etc. (data and analysis to be provided by LDSS)
 - 1. How much did we do? - required
 - 2. How well did we do it? – if data available/optional
 - 3. Is anyone better off? if data available/optional
 - 4. Story behind the data
 - 5. Identification of each indicator as a strength and area needing improvement
- vii. Workforce and Workplace Issues – (data and information to be provided by the LDSS) (data and analysis to be provided by LDSS)
 - 1. How much did we do?
 - a. Organizational chart, with numbers of child welfare workers, supervisors, and administrators, etc.
 - b. Number and types of vacancies
 - 2. How well did we do it?
 - a. Average educational/license attainment levels of workers and supervisors
 - b. Do staff members have appropriate tools to support and carry out their jobs? - Provide numbers/percentages of workers and supervisor who have:
 - i. Laptops
 - ii. Cell phones
 - iii. Access to state cars
 - 3. Is anyone better off?
 - a. Retention and turn-over rates
 - 4. Story behind the data, including:
 - a. Are staff members appropriately trained for their jobs?
 - b. Do staff have adequate office space and supplies?
 - c. Are buildings well-maintained?
 - d. Workforce training – do staff understand & follow best practices, evidence-based interventions, and other practice protocols in their direct work w/ families?
- viii. Systemic Factors (information to be provided by the LDSS, based on stakeholder focus groups and other sources)
 - 1. Consumer access
 - a. Are buildings family-friendly?
 - b. Are buildings accessible to families (e.g. when are services offered?)
 - c. Are programs based in the community?
 - d. Is consumer feedback actively encouraged and sought out?
 - 2. Family engagement
 - a. Are families engaged in all aspects of their care, including decision-making?
 - b. Are families treated with dignity?
 - c. Are cultural awareness, knowledge, attitudes, & skills applied to work with families and children?

- d. Are services, interventions, and protocols developmentally and culturally appropriate?
- 3. Agency Management
 - a. Are LDSS agency goals tied to practice model fidelity and child/family outcomes?
 - b. Is agency/clinical supervision tied to practice model fidelity and child/family outcomes?
- 4. CFSR Systemic Factors
- 3. All data should be presented in tables and chart. Narrative sections should focus primarily on the story behind the data, and should be no longer than one page per program area.

Appendix C – Quality Assessment Report

Date of Submission -

Jurisdiction –

Address –
Phone –
Fax –

Director –

Email address –
Phone –
Fax –

Assistant Director –

Email address -
Phone –
Fax –

QAR Coordinator/Primary Contact –

Title –
Email address -
Phone -
Fax –

Signature of LDSS Director - _____

Note – all reports must be submitted to SSA electronically.

(Include all required elements, as described in Appendix B of the DHR/SSA-LDSS Child Welfare Continuous Quality Improvement Policies and Procedures Manual.)

Section 1 – Description of the Jurisdiction

Section 2 – Description of the LDSS’s Child Welfare System

Section 3 – Results from Stakeholder Focus/Work Groups

Section 4 – Results from Citizen’s Review Board for Children assessments

Section 5 – Results from Local Supervisor Review Instruments

Section 6 – Results from DHR/SSA QA Monthly Reports of MD CHESSIE Required Elements

Section 7 – Primary Indicators (follow order in Appendix B)

Section 8 – Secondary Indicators (follow order in Appendix B)

Appendix A

1. Dates, participants (names & role) for focus/work groups

Note: QAR Report should designate each indicator as a preliminary area of strength or ANIs (note – an indicator may be found to be strength for one client population but an ANI for another client population).

Appendix D – Continuous Improvement Plan

Date of Submission - _____

Jurisdiction –

Address –

Phone –

Fax –

Director –

Email address –

Phone –

Fax –

Assistant Director –

Email address -

Phone –

Fax –

QAR Coordinator/Primary Contact –

Title –

Email address -

Phone -

Fax –

Signature of LDSS Director - _____

Following the framework of the QAR, provide the following information (in this format) for each indicator:

1. *Areas Needing Improvement (ANIs)*
 - a. *Child Safety*
 - b. *Primary Indicators*
 - c. *Secondary Indicators*
 - i. *Investigations,*
 - ii. *In-Home Services*
 - iii. *Out-of-Home Services*
 - iv. *Adoptions*
 - v. *Resource Homes*
 - vi. *Workforce/Workspace Issues*
 - vii. *Systemic Factors*
2. *Strengths*
 - a. *Primary Indicators*
 - b. *Secondary Indicators*
 - i. *Investigations,*
 - ii. *In-Home Services*
 - iii. *Out-of-Home Services*
 - iv. *Adoptions*
 - v. *Resource Homes*
 - vi. *Workforce/Workspace Issues*
 - vii. *Systemic Factors*

Item # - _____	Program Assignment Area - _____	How much/how well/better off
Strength/ANI - _____		
Affecting Child Safety?		
Ongoing/new strategies to address/improve the ANI/strength:		
Long-term goals (three years):		
Interim goals (every six months):		
Data table and/or graph for each measure to be used to monitor progress (including data as far back as possible):		

**Note: All narrative sections should be brief, and required elements for each ANI/strength should be presented on no more than one page per ANI/strength*

Appendix E – DHR/SSA QA LSRI – 2nd Level QA Review Report

LDSS - _____ Date of Report - _____

Time Period Reviewed - _____

Number of LSRI's assigned to the LDSS during the period under review - _____

Number of LSRI's completed during the period under review - _____

Number of LSRI's reviewed - _____

Number of LSRI items reviewed - _____

Correlation Rate - _____

The LDSS is found to be in compliance/not in compliance with the Local Supervisory Review Policy.

Report prepared by:

Date:

DHR/SSA QA Staff

LSRI Cases Reviewed:

<i>LSRI Module</i>	<i>Case/Client ID</i>

Appendix F – Monthly QA Report on Required MD CHESSIE Elements

LDSS - _____

Date of Report - _____

Time Period Reviewed - _____

Required Elements	Total Number of Cases Required to have Element completed	Actual Number of Cases with Element completed	Completion Rate	Does Completion Rate Meet Standards?***
Total AFCARS data elements				
Specific AFCARS data elements (TBD)				
Total NCANDS data elements				
Specific NCANDS data elements (TBD)				
SAFE-C*				
MFRA*				
Well-being data fields for OOH Placements:				
medical examination within 10 days of entry				
comprehensive assessment within 60 days of entry				
enrolled in school				
with no psychiatric hospitalization during the year				
CPA/ILP home data entry completion				
LSRI completion data				
Number of clients (per PA area) with no contact in over 30 days				
StateStat Exception Report data				
Other data fields and assessments/reviews as needed				

*Based on completion of assessment every 3 months for each child.

**Standard = 95% completion/fidelity.

Note: Source data reports not already distributed to LDSS will be attached.

Report prepared by:

Date:

DHR/SSA QA Staff

Appendix G – Continuous Improvement Plan Semi-Annual Report

LDSS - _____ Date of Submission - _____

Time Period Reviewed - _____

Director –

Email address –

Phone –

Fax –

Assistant Director –

Email address -

Phone –

Fax –

QAR Coordinator/Primary Contact –

Title –

Email address -

Phone -

Fax –

Signature of LDSS Director - _____

Following the framework of the QAR, provide the following information (in this format) for each indicator:

ANIs

1. Child Safety
2. Primary Indicators
3. Secondary Indicators
 - a. Investigations
 - b. In-Home Services
 - c. Out-of-Home Services
 - d. Adoptions
 - e. Resource Homes
 - f. Workforce/Workspace Issues
 - g. Systemic Factors

For each ANI:

Item # - _____	Program Assignment Area - _____	How much/how well/better off
ANI - _____		
Affecting Child Safety?		
Met long-term goal?		
Met interim goal for this period?		
Update on implementation of strategies:		
Data table and/or graph for each measure (including data as far back as possible):		

**Note: All narrative sections should be brief, and required elements for each ANI/strength should be presented on no more than one page per ANI/strength*

Completion Rates and Findings of the LSRI and the LSRI – 2nd Level QA Review

- Completion rate of LSRI
- Findings from LSRI – 2nd Level QA Review
- Corrective action plan, if needed, if the LDSS was found to not be in compliance with LSRI policies

Analysis of Findings Based on the QA Report on Required MD CRESSIE Elements

- Summary of findings from the monthly QA Reports on Required MD CRESSIE Elements
- Corrective action plan, if needed, if the LDSS was found to have any completion rates not acceptable

Other Child Welfare Indicators/Outcomes, as Appropriate

To be determined by DHR/SSA and/or LDSS, depending on progress or lack of progress in other areas, additional federal or state requirements, or other needs.

For Each Area of Strength

DHR/SSA QA and the LDSS will determine an appropriate schedule to review data on areas of strength. For those review dates, provide the following information (in this format) for each indicator:

Strengths

1. Primary Indicators
2. Remaining Primary Indicators
3. Secondary Indicators
 - a. Investigations
 - b. In-Home Services
 - c. Out-of-Home Services
 - d. Adoptions
 - e. Resource Homes
 - f. Workforce/Workspace Issues
 - g. Systemic Factors

Item # - _____ Program Assignment Area - _____ How much/how well/better off
Strength - _____
Data:
Update on implementation/continuation of strategies:
Data table and/or graph for each measure (including data as far back as possible):

Appendix H – Targeted Case Review Pool of Questions

To be updated Spring/Summer 2010.

Appendix I – Case Review & Interview Questions/Items

To be updated Spring/Summer 2010.

Appendix J – Guide to the Targeted QA Review

To be updated Spring/Summer 2010.

Appendix K – LSRI Quarterly Report Guidelines and Template

Currently, an LSRI Quarterly Report is due on the last day of each quarter, to be submitted from each LDSS to DHR/SSA QA staff. This report assists in tracking assigned and completed LSRI and alternate LSRI, and may eventually be eliminated once an automatic LSRI assignment function is created in MD CHESSIE. LDSSs will be informed if/when this report is no longer required. A template of the report is shown below, although the actual report is required to be completed in Excel and is available from DHR/SSA QA staff.

Month / Year	Case ID #s received from DHR for review	Check box if case assigned was reviewed	ID # of case reviewed if alternate was provided for review
<i>Note: Please add cell if needed for additional case ID#.</i>			
# of cases assigned for review this quarter:			
# of case reviews submitted this quarter:			
# of outstanding reviews this quarter:			
Concerns / Barriers:			
Date Submitted:			

Appendix L – Report Submission Guidelines for LDSSs

1. All reports must be submitted electronically to SSA; reports should be emailed to the Executive Directors of SSA, the Manager of Research and Evaluation, and the Supervisor Quality Assurance.
2. A hard copy of reports may also be submitted, but this submission does not preclude the requirement to submit reports electronically.
3. Report templates will be available on SSANet or from DHR/SSA QA staff. All reports must be submitted in these formats.
4. Reports may be submitted in PDF, Microsoft Word, or Microsoft Excel.
5. The Supervisor of Quality Assurance will contact the LDSS to acknowledge receipt of all reports; please contact the Supervisor of Quality Assurance with any questions regarding DHR/SSA's receipt of a report.