

Arkansas Child Welfare Renewal: An Agenda for Change

A. Arkansas PIP core strategies

AR DCFS has embraced the CFSR process by internalizing key learning from the Statewide assessment and on-site review. Months before the issuance of the Final Report DCFS began to put in place immediate and long term strategies to assure safety, permanency and well being for vulnerable children and families across the State.

The first stage of this work was the convening of a set of PIP workgroups to begin to frame the strategies necessary to the Areas Needing Improvement (ANI). The work of these groups was: Recruitment and Retention of Foster and Adoptive Homes; Placement Stability and Placement Capacity; Staff Recruitment and Retention; Service Array; Model of Practice; Independent Living; and Adoption.

From these workgroups the major strategies for the PIP were formulated. The strategies were shaped in order to make the PIP an over-arching driver for long term positive change as well as to provide a sharp focus for immediate tactics that set us on the right path for measurable improvements for both the short term and the long term.

We are guided by confident knowledge about the “*what when why where and how*” of child welfare systems change and transformation. And we are drawing from a complex evidence base to make it so. Without minimizing the daunting challenges that face various sectors of our system, we believe that we are presented with both urgency and opportunity. In the years ahead an effective child welfare system will make an essential contribution to a healthy population in the State of AR, one capable of meeting the social and economic demands that confront the State as a whole. This PIP is designed to make a determining contribution to these needs by 1) building a comprehensive practice model to guide the work of the field and central office supports, 2) designing and implementing resilient communication, professional development, and change management strategies, 3) growing our service array (with attention to the variety, efficiency, and effectiveness of procured services as well as the variety of services and supports organized through community partnerships), and 4) enhancing the State’s QA to become a robust system for results monitoring and practice improvement all of which, taken together, will serve to enhance the safety, permanency and well being of Arkansas children and families in ways that are measurable and sustainable . Through the PIP we will capitalize on the political support for DCFS from the governor’s office, the energy and commitment of new leadership, and the growing readiness of the field to systematically improve practice Statewide.

The practice model is our leading edge of change. Through its development, implementation, and monitoring/ improvement we will be able to focus strategically on those outcomes, systemic factors and related items that require immediate or short term attention, while consistently maintaining a view of our long term objective to build and sustain a consistent, outcome focused, family and community-centered practice model. At the same time, our distinctive approach to the practice model will strengthen its resilience. As social and political priorities with child welfare implications manifest themselves, our design will permit us to adapt, refocus – and stay on our long term objectives.

The practice model is growing through an iterative process as the founding principles for the model become specified over time, through consultation and feedback with a variety of internal and external stakeholder groups. We believe strongly that this iterative process will help the model take root, contributing to a changing practice culture at DCFS as practice changes and gets inscribed in the practice model itself.

Below is “page one” of the practice model which illustrates some of the overarching concepts guiding practice model development.

Arkansas Practice Model **A Framework for First Steps and Next Steps**

Division of Children and Family Services (DCFS) Mission Statement:
Our mission is to keep children safe and help families. DCFS will respectfully engage families and youth and use community-based services and supports to assist parents in successfully caring for their children. We will focus on the safety, permanency and well-being for all children and youth.

The Arkansas Practice Model Goals :

- Safely keep children with their families
- Engage families for effective family decisions
- View child welfare work from prevention to permanency throughout families’ involvement
- Sustain community partnerships and community based services
- Guide the work in the field in a comprehensive manner
- Direct system support to the field
- Include organizational development, change management, and skills based training as basic components of the model
- Maintain a model that is rooted in a set of core skills that apply to everyone
- Use a Continuous Quality Improvement approach

Guiding Principles: these apply to all of our work with children and families from prevention to permanency:

- **Family Focus:** we listen to and address the needs of our families in a respectful and responsive manner that builds upon their strengths. Our services promote meaningful connections to family and community
- **Excellence:** we work towards excellence through efficient, effective, and responsible public services; we communicate openly and honestly, and adhere to the highest standards of ethics and professional conduct
- **Accountability:** we maximize the use of resources and develop and use data to evaluate performance and make informed decisions to improve results; we are good stewards of public trust
- **Teamwork:** we work collaboratively with customers, employees, and public and private partners to achieve positive outcome

This framework for “first steps and next steps” is intended to engage staff in an ongoing dialogue, played out in day to day work, about how they are practicing now in relation to the goals and strategies for where the Division needs to go in the future for the long term. It is this awareness of the complexities of moving *from* a varied collection of practices which describes the work of the Division *to* a coherent practice model that guides the PIP towards CFSR outcomes through a growing awareness of the need for change at multiple levels of the system – from legislative amendments, to the guiding policy framework, to management and leadership styles, to the concrete day to day encounters with families in the field, to the “customer service” principles that guide interactions between support staff and the public, to the underlying framework of *values* that shapes employee understanding of the work of the division. This is a long term task.

The governing “theory of change” steering the work of this PIP towards steadily improving outcomes is built on a foundation of a new focus on organizational development in child welfare. For a generation or more the fundamental tenets of best practice in child welfare have been available to the field. These could be extracted from numerous studies, reports, curricula, and promotional literature regarding family centered practice. *What* needs to be done is not a secret. The missing piece of sustainable child welfare transformation is a relentless focus on *how* organizations change. This is an extensive topic about which we are tempted to digress but will for now limit to saying that most (failed) efforts at

fundamental organizational change, or transformation, are built on a formula of structural change combined with over-valuing the good intentions of the present moment. This PIP, on the contrary, is built on a thorough understanding of contemporary organizations and change management strategies. This is reflected in the fact that every “what” of the strategies and activities, is embedded in the “how” of a multifaceted view of organizational change.

This makes the AR PIP a complex and organically integrated driver of change for the short and long term. The core strategy of the PIP is the practice model. We know that poor outcomes for children and families are driven by systemic problems – the accumulation of multiple causes and effects across the system that result in poor outcomes – not single causes. By using the practice model as our principle strategy we will over the long term address these multiple systemic issues, “from prevention through permanency” as we put it – to keep children genuinely safe (as opposed to isolated from harm), to enhance developmental opportunities for increased well-being through improved education, healthcare and mental health services, and to create conditions to improve access of children, adolescents, and young adults to a spectrum of best permanency options -- from traditional adoptions to potential subsidized guardianships. The impact of the PIP will be discernible through a spectrum of systemic results proximate to longer range outcomes embracing safety, permanency and well-being. These include the reorganizing of the DCFS policy framework to streamline and enhance the rationality of the Divisions policy documents while at the same time strengthening the policy process and the capacity of policy to support practice across the State consistently and with renewed authority. The renewed policy framework will be linked to practice guides to shape the professional discernment of frontline staff to make humane and permanency focused decisions at many points in the casework process. Practice improvements will themselves be supported by skill-based training and field consultation to strengthen the behaviorally specific work to strengthen families relationships leading to secure permanency outcomes in the context of family-centered safety and enhanced well-being. Included in this training and overall practice development will be case planning processes built on family engagement, quality visits with families that support case goals, team work with family support networks and increasingly individualized services. This work will lead to practice that is increasingly effective in assessing and addressing families’ needs in both in home and out of home care.

To use the practice model development and implementation process in this way we have designed it to reflect an intentional development period, a strategically calibrated implementation process, and an ongoing practice improvement approach. *Critical here is to understand the relation between simultaneity and sequence both within the PIP and in the pursuit of systems transformation as a whole.* These three elements – development, implementation, and monitoring/improvement – both form a sequence and occur simultaneously – with a shifting center of organizational gravity as a balancing point. This means that

development, implementation, and practice improvement are always ongoing, with the relative emphasis shifting over time from development to implementation, guided by quality improvement activities; and we hope, shifting back again as a sustainable way to deal with social changes and emerging conditions that a resilient practice model needs to confront.

Accomplishing the goal of a sustainable practice model focused on outcomes drives our decisions to: 1) use a casework process analysis to document definitively the backbone of the Division's core work process supporting good practice; 2) adopt a meeting map approach to effectively and whenever possible inhabit the existing infrastructure of meetings, work groups, commissions and other forums and gradually transform them with the new design; and 3) a consultation format employed at multiple levels of the system, in the field, with stakeholders and communities etc... that will both gather input and keep people informed of the strategic direction guiding the Division. This will, over the development of the practice model, help us create a discriminating change agenda, allowing us to see *what needs to change and what can and should remain the same*, specifically, in our work. Identifying and strengthening practice leaders and building on evidence of successful practice is a key to this effort. Too often the nature of changes has been assumed – start a new program, add funding, tell workers to follow a new procedure or use a new form – rather than recognizing more discriminating changes – shaping an existing practice to conform to a value and standard for how we treat families, adjust a policy that simplifies a workflow, improve a judicial or other stakeholder partnership, revise information technology requirements used for reporting – which individually or taken together enact an effective response. Further, development activities can be targeted to particular groups according to the roles that they need to play in the system, whether focusing on the leadership and management responsibilities that need to be emphasized with Area Managers, specific supervisory skills, or frontline core practice skills, for example. Note that the development phase of the practice model addresses all phases of the work of attending to safety, well-being and permanency, from the formation and/or consultation with community partnerships to strengthen resources for family support and prevention, through improved processes for investigation, placement prevention, case planning for children in foster care, and timely permanency for children and youth.

This PIP is not a collection of activities and tasks so much as it is a comprehensive agenda for change. This means that strategies are reflected in and build upon one another. This is the case within the practice model strategy as well. Development is reflected in the implementation phase. This is conceived in a particular way. We recognize that we cannot freeze the system, fix practice, revise policy, change technology and retrain everybody and then unfreeze the system – as a less thoughtful approach might imply. Fundamental to successful systemic change is the assumption that direct practice with families, and all the attendant support work needed to make best practice run is always going on in real time throughout the course of our PIP activities. Our implementation section

takes that into account, by implementing components of our practice model with attention to the critical priorities in our current environment in Arkansas right now.

Currently, Arkansas has a tremendous opportunity to make unprecedented progress in its child welfare system. The Governor has made it a top priority of his first administration, singling out attention to the child welfare system and proposals for improvement in his recent State of the State address. We all know that political will is an essential ingredient for dramatic progress in the system. However, maintaining that political will requires attending to immediate high priority items. The essential “martial art” of systemic transformation is to address immediate, politically charged, redline priorities while at the same time using those very issues as leverage points for the long term strategic direction of the Division. This is absolutely necessary in order to break the cycle of crisis driven management treating symptoms that leave root causes unaddressed or, worse, sets in motion a chain of negative unintended consequences that future leaders have then to unravel at great effort and cost. It is increasingly clear that single issue emphases – chasing symptoms around a system – leaves fundamental systemic change addressing root causes untouched.

There are some noteworthy examples of the ways in which our PIP includes review and analysis of specific types of cases as focal points with systemic implications. One of these areas will be attention to the issue of “stuck kids,” children whose length of stay in the system is too long and whose case plans have lost an outcome orientation. The emphasis of this work will be to analyze case work processes to optimize and clarify the most appropriate and timely decisions that need to be made on behalf of our youth. It will include practice improvement of case planning processes to focus on the need for permanency, including the ability to work effectively on concurrent planning for timely permanency. And it will address the engagement, teamwork, and relationship-building necessary to family-centered practice development. This will result in strengthened adoptions, especially special needs adoption, child specific recruitment for adoption, as well as the exploration of innovative ways to build adoption communities of support to maintain and sustain rewarding experiences for families undertaking challenging adoptions. In addition this work will yield improvements in guardianships, relative permanency options, and alternative best permanency options for youth whose current prognosis all too often is physical and chemical incarceration, mental illness, substance abuse, homelessness, and swathes of collateral damage to themselves and others on a path to adult corrections. It should also be noted that our intentionally comprehensive systems emphasis includes the recognition that improved practices for permanency with any population pushes towards the front end of the system, where the practice of strengthening and building relationships with families as early as possible leads to permanency as appropriately as possible. As one author from the NRC for Family Centered Practice one put it several years back: “Prevention is the soul of permanency.”

In addition to our focus on the “stuck kids” population our approach to adoption more broadly is a good example of this implementation approach. Adoption is a high priority issue for the State for a number of reasons. Therefore it is a number one issue on our practice model implementation agenda. Addressing it squarely means several things: clarifying the methodology we use to determine the number of children waiting for adoption; analyzing the work process so that all staff understand fully (as well as improve) the process we use to recruit adoptive homes, get these homes approved, match children with waiting parents, and organize all the administrative and practice pieces that need to be in place to finalize adoptions. At the same time we meet this critical priority agenda by increasing the numbers of adoptions, this work is surrounded by a variety of closely connected and more far reaching activities. We simultaneously attend to the quality of adoptive practice. We set in motion training, consulting, and coaching with adoption specialists on successful matching and other key practice issues. This includes a strong emphasis on post adoption support activities so that adoptive placements that are made are supported when the going gets stressful (with DCFS children who all carry some degree of trauma).

Further, at the same time as we support deepening the practice of adoption we have to be aware of surrounding systemic issues. Treating one symptom – the sudden recognition of growing numbers of children “freed” for adoption – will not solve a problem. Treating a symptom may make it disappear temporarily, while it is the focus of attention, allowing other problems to appear elsewhere in the field. Using the “tank and flow” metaphor favored by systems’ thinkers to understand this kind of problem we have to look at what is happening to our child welfare population surrounding this adoptive process. This leads us to look for analytical and practice strategies to address children “stuck” at high levels of care, children plagued by the traumatic effects of multiple placements, older youth in care who may benefit from a new emphasis on young adult adoption or other permanency arrangements. Ultimately, this work backs into our prevention agenda, to our analysis and improvement of our primary prevention infrastructure, our reporting and investigation procedures, placement prevention services, and our analysis of children who come into care for short periods of time. Ultimately, keeping as many children safely at home with birth parents allows us to focus resources on the right children and help them find new families through timely adoption. Ultimately any single outcome is enhanced and supported by unified practice integrated through the practice model.

This is one example of how implementation of the practice model hits a high priority concern, takes opportunities to show measurable results in the relatively short term, while at the same time setting in motion work that will serve the Division over the long term. The same type of interrelated work characterizes our PIP and practice model work in the safety arena, prevention efforts to stabilize the front end of the system to assure increasingly that only children come into the system who cannot be maintained safely with birth families, case planning to begin to assure that foster care is a temporary service on the way to

permanency, or the way in which our work on the National Youth in Transition Database gives us a short term priority driven by the need to collect data concerning outcomes for our youth, and turns it into an opportunity to revision our system of transition services serving youth in transition to adulthood.

As we build PIP components Statewide, we will intensify implementation through our “phase-in” sites. Statewide implementation and the phase-in sites are concurrent activities. We recognize that the system cannot change instantly through a misdirected “implementation by proclamation” approach. We recognize further that we need to exemplify our vision of a well functioning and well run child welfare system to staff and stakeholders in order to build on the foundation of Statewide activities.

The phase-in sites are a staging and scaling up strategy. The phase-in sites are accelerators of systems change. They are intentionally designed for deep practice culture change, and for energizing practice leaders, trainers, and internal consultants who will work around the State. They are a strategy to build learning-intensive improvement cycles, and to cultivate funding partners both local and national. Statewide we will be working on the full range of PIP strategies while at the same time igniting deeper child welfare practice culture change involving multiple counties in successive cycles. This approach will deepen ownership of the child welfare renewal change process, making change sustainable and practice improvements resilient.

Planned as 2 county sites in SFY 2009, and 4 counties in SFY 2010, and expanding from there, the sites will be selected according to capacity, progress and commitment to the AR transformation agenda initially (for the first sites), and then, tentatively (this has yet to be officially decided upon) based on some kind of a letter of intent process that documents the commitment, partnership and capacity of proposed counties to begin, and to sustain, the Arkansas child welfare renewal. Though this will take us beyond the term of this PIP, the process is a key component, initiating a progressive renewal process we will see through in the years following this particular PIP.

Criteria for the initial phase in counties will be identified to grow participation, deepen buy-in for sustainability, and accelerate change occurring *concurrently statewide*. Criteria we will use to determine phase in sites include:

Data profile: Includes the dynamics of children entering and leaving care, the reasons for child welfare involvement, patterns of placement (types, numbers, levels of care) and length of time necessary to achieve permanency.

DCFS initiatives: Human service workers in schools, Family Resource Centers, MDT and CSC activity as well as locally innovative practices

Community collaborative activities: Ability and past experience engaging partners and stakeholders in the work of supporting children and families.

Public partners: Coordinated work with other county services such as income assistance, public health, county extension service, daycare and employment services

Providers and related service organizations: Organizing services either contracted or funded through other funding streams to form effective networks.

System of care participation: Integrating the State's effort with SOC and the child welfare rebuilding process, drawing together CAASP councils and other mental health services.

Legislators: Building and sustaining political will through good communication and the determined pursuit of measurable outcomes is a foundation of our efforts.

Judicial / Court involvement: Partnership with the courts is fundamental to all of our efforts.

It must be emphasized that the phase-in sites are specifically intended to work in a complementary way with state wide strategies. To repeat, as we develop and implement major components of the practice model statewide, we will be focused in the growing number of phase-in counties on the deep work of transforming the practice culture in a way that will accelerate the *concurrent* movement for change statewide.

The third component of the practice model strategy involves QA activities to support the model in the implementation phase and then continually thereafter. These include an administrative case review designed to determine procedural compliance in cases under review and to assure a foundation of sound casework activities and decisions to build the practice model on, as well as a process to visit foster homes and support their efforts to meet State licensing standards. The QA activities in this section are best seen as continuous practice improvement activities including spec-ing out a decision support system to enhance and refine the use of data for management and practice, improving the QSPR process to make the use of the findings of the review available and applicable to practice improvement planning, and ongoing efforts to make CHRIS enhancements to assist supervisors and managers in their practice.

The second governing strategy of the AR PIP consists of inter-related communication, professional development, and organizational change management activities. Communication will receive unprecedented attention over the course of this PIP. Whereas in the past DCFS has been beset by inadequate or inaccurate communication within central office, within the field, and between

both, the communications to message the practice model and all ongoing improvement activities will begin with communication strategy and methods – the creation of a so-called “message palette” to build our capacity to communicate consistent, appropriate, accurate, and high quality communications to various constituencies who need to be engaged, consulted, or informed about the strategic direction of the Division. This will introduce a new level of message discipline whereby we mean what we say and say what we mean to the highest degree possible in the service of our short and long term objectives for the practice model. This will include the use of the communications strategy to engage critical stakeholders such as judges and judicial staff in the effort to win them over with new trust and confidence in the Division’s practice model and transformation process. Ultimately this approach will become institutionalized as an effective system of organizational communication, improving the flow of timely, consistent, and accurate information. We have a long way to go in this area. But the change starts with the recognition of our need to focus on this fundamental capacity.

The second component of this strategy is a comprehensive effort to transform and reposition our entire subsystem of professional development under our IV-E training contract. DCFS currently has a sizable group of contracts with a number of universities around the State in a group known as the University Partnership. The partnership conducts all DCFS training. The repositioning and transformation of the University Partnership will take place through reviewing and revising all of the curriculum used currently to train staff to assure that it supports the practice model specifically in all of its aspects, and that the system for in-service training is guided by the goal of reinforcing and deepening core practice skills that can potentially be developed over a lifetime of practice – skills such as engaging families effectively, identifying and working with strengths, developing the ability to conduct difficult conversations with or on behalf of families. We also envision adding additional skills into this mix such as conducting effective group work – whether for family team meetings or community partnership forums – as well as work on leadership and management development, and effective supervision. The University Partnership also operates on our behalf a system of “field trainers” who work directly within DCFS field offices on a variety of issues. As we reposition this system, the field trainers will work to train, consult, and coach new and experienced workers with families on their caseloads in real time settings. It is through approaches such as these (and these are examples and not intended to be a comprehensive representation of the strategy) that we intend to move beyond a simple “training” model to system for effective and verifiable skills transfer tied back to the practice model.

The previous example forms a good transition to how we view and intend to use effective organizational development strategies. This is a key to how we will effectively drive a change in the practice culture at DCFS. In order to encourage ownership of the practice model we will in every Area and every County office build a network of “practice leaders” to assist with the development and

implementation of the practice model. These will be our “product champions,” people who understand the strategic direction we are taking and are able to speak about child welfare best practice to colleagues and stakeholders from a value base emphasizing respect, family engagement, relationship building, an understanding of the role of family support in all family forms, and how vitally important permanency is for children. By identifying, expanding, and supporting our networks of practice leaders around the State we hope to “tip” the practice culture towards the practice model and the advantages it holds for enhancing professional identity, managing work effectively, demonstrating greater success with families and hence greater worker satisfaction, creating appropriate means to handle the secondary trauma that is almost inevitable in child welfare work, and creating a sense of child welfare as a vocation. These are lofty goals which will be realized beyond the terms of this PIP, but these are goals we must pursue, and this PIP is an essential starting point to realize them.

Other aspects (again not inclusive) of our organizational development strategy that integrate the work of the PIP and will result in improvements across CFSR outcomes and items include team development strategies at multiple levels of the organization and community partnership development strategies to create a greater awareness of how stakeholders, residents, and local organizations all share in the work of building communities in which children can be safe and even thrive. Also noteworthy in this strategy is the focus on leadership. By focusing on leadership, highlighting the work of practice leaders, supporting good supervision, and providing consultation and training on Area management and leadership, our hope is to address workforce development issues by creating an identifiable career path in child welfare which will, again in the longer term, address succession planning and assure that there are younger staff mentored with the practice wisdom of their more experienced peers to mitigate the current “graying of the child welfare workforce.”

Our third major PIP strategy addresses our need to build a service array. As our practice model is developed and takes hold, the increasingly coherent practice of DCFS needs to mesh with a developing service array that meets the needs of our population for individualized and community based services and supports focused on safety permanency and well-being. These too need to be considered extensions of the practice model. Our service array strategies are designed to achieve these aims. Our service array assessment process is designed to meet multiple objectives including mapping types and availability of services across the State, building a community based service development process, and community engagement. The service array development process will have a capacity building focus. Individuals to be surveyed are intentionally selected on the basis of their being identified as significant community level stakeholders with whom contact will be maintained over time. This will create a constituency of community based stakeholders to be engaged in new or existing community partnership settings to begin or enhance a process of community and county level organizing of services and resources that can be utilized to support families. These services

for both in home and out of home cases will include family and parenting support services, educational services including pre-school and advocacy for special education programs, early intervention services, placement prevention services, behavioral health, domestic violence, substance abuse treatment, sexual abuse offender and victim treatment, and others determined by data for particular counties and areas. These would also include addressing cultural aspects such as language barriers. This will also reinforce the practice model goal of working to have communities assume greater responsibility for their children rather than expecting one State agency to meet that challenge. This work will be further enhanced by DHS department-wide efforts, such as coordinating the work of DCFS as closely as possible with the System of Care initiative.

As we develop and move forward with statewide expansion, service array will expand according to the uniqueness of various communities, serving children and families through some variety of the strategies indicated below:

Community Partnership

Community partnerships consist of community level teamwork to build community level concern and responsibility for the well-being of children and families.

Purposes of community partnership include:

- Cross functional teams of administrators can meet to review service coordination and collaboration
- Partners share learning and create informal supports for families
- Activities over time support an ongoing community needs assessment
- The group can offer a setting for a parent advisory forum for DCFS families
- Partners contribute to meeting high priority needs such as foster care recruitment
- Stakeholders support quality improvement activities

A key function of the community partnership is its role in sponsoring a forum for customers of the system to discuss their experience of the system. This is needed to repair a minimally trusting relationship between families, the community and DCFS. Restoring (or creating) a measure of trust between DCFS and the community is necessary to make investment in the community successful. The vast majority of families who encounter DCFS experience only a child protective investigation. Families (almost everywhere nationally) have a damaged and damaging understanding of the child welfare agency. This is reflected in workers as well. Complicated circumstances leave workers with the burdens of secondary trauma and a diminished ability to engage families in productive relationships that are the foundation for improvement in families' capacities to care for each other. Facilitating groups such as this will be closely

related to the Family Team Meeting service enhancements and will be staffed by the facilitators contracted within the phase-in sites.

Intensive Family Services

IFS will be a major service enhancement, initially in the phase-in sites. A redesigned IFS program will be available to those families needing intensive service in order to keep families at home. The specifics of the model redesign are still being decided, but it will include varying degrees of service intensity and collaborative activity with county social workers to make sure the gains of the service can be sustained by the family over the long term. While the majority of cases will focus on placement prevention, some cases will be taken to assist with family reunification, or to prevent the disruption of a critical placement or adoption.

Fostering family connections

Foster care is a temporary service for children before they are reunified or move on to another permanency option. Its primary function is to facilitate the repair and strengthening of family relationships and secondarily to support adoption. Increasingly this will include building constructive relationships between birth and foster families in communities. A major service enhancement will be the Family Team Meeting. FTM's will be conducted to make foster placements work successfully towards specified case goals.

Youth leadership boards and youth investment partnerships

A final core component of the child welfare renewal will be to dramatically alter the use of funds devoted to older youth in care and aging out of care. Rather than hand out grants and conventional skills training, our approach will emphasize youth leadership development, and diverse partnerships to enhance the social and material prospects of a successful transition to adulthood.

Additionally, in order support and strengthen the integration of our overall system, we will conduct a contract review to assure that practice model standards become a part of the contracting process, that services are procured that meet our practice model standards, and that training and consultation is available to providers so that increasingly case planning through the casework processes developed through the practice model become an integral part of accessing services through our providers. In this process, we will additionally assess more efficient and effective ways to contract for services which may include such mechanisms as lead agency models for certain categories of services so that service coordination and integration becomes a feature of the procurement process itself. This will enhance our capacity to work with providers to develop new services that are responsive to individualized assessment and service planning always with the goal of achieving the outcomes that are the prime directive of our practice model: keeping children safely at home with their birth families, utilizing placement as a temporary service supporting reunification,

and if that is not possible adoption or guardianship. Children will not grow up in care. Our mantra is: family, family, family, family, family.

Finally, for the highlights of this discussion, another area of service array development will be to enhance foster care recruitment strategies and begin to develop more foster care homes supported to work with specialized populations, younger or older children, special needs like drug affected babies.

Taken all together this will mesh with practice model and organizational development strategies into the Arkansas Child Welfare Renewal: an Agenda for Change.

Finally: strategy four. Our enhanced QA system ties the PIP together. QA is a “both – and” strategy. As we ramp up and roll out the PIP, we will **both** develop a statewide infrastructure to improve data collection and conduct training and consultation to use data for effective management of the system, **and** at the same time attention to continuous quality practice improvement will be woven throughout the multiple facets of each strategy so that continuous quality practice improvement will take place in real time practice settings, accelerating a “practice, review, and improve” cycle in field offices as management data informs Central Office and field management staff. This by design avoids the risk that shadows QA in many jurisdictions, the risk of QA becoming a retrospective compliance activity too distant from the field to inform real time practice improvements.

As a part of this strategy, we will refine our IT capabilities to support practice and modify our data collection and reporting to create essential management and practice improvement reports within and across program areas. These product deliverables will be a part of the final work plan produced with HZA. Then, through training and coaching involving DCFS staff, HZA staff, partners and additional TA providers we will use data not only to manage at different levels of the organization, but to improve practice and qualitatively document practice improvements as needed in our “practice guides.” As a part of this process our QA system will utilize the QSPR instrument, as well as a number of other data reports including an integrated analysis of performance reports supplied by HZA, and additional specifically targeted reports on specifically identified issues.

The AR Program Improvement Plan (PIP) provides a good opportunity to strengthen the capacity and the role of the QA unit to improve practice across all of the PIP strategies and thereby contribute to sustainable systemic change. The primary approach to enhancing our capacity to ensure effective and thoughtful measurement of quality outcomes is to build on the existing work with HZA. We have a long standing and integrated partnership with HZA, who has been involved with the division for many years. We look at them as “part of us” rather than an outside consulting firm. Contracting Quality Assurance to HZA will strengthen our PIP. The HZA principals are closely involved in this project, in

hiring and in “QA of the QA.” They understand the direction the Division is taking in transforming child welfare practice and the system that supports it in Arkansas to ensure children and families work towards best permanency outcomes. By joining the expertise assembled through the HZA contract with DCFS staff and partners, we will strengthen the validity and reliability of our performance measures. Secondly, we will build a growing team of QSPR reviewers who understand the AR DCFS practice model. This will enhance our internal capacity to measure practice improvements, create meaningful practice improvement plans, and to train and coach staff on best practice. The new Quality Assurance Manager will be a part of the Division’s Executive Staff.

B. Baseline Data

The first step in the narrative of DCFS QA and CQI is developing our baseline. Our primary data source for PIP reporting is the State’s Quality Service performance Review (QSPR) a review tool that is modeled on the CFSR. In order to enhance the use of the tool to provide an effective baseline, we plan to conduct a set of rigorous training, consultation, and practice development sessions to accomplish a number of critical objectives: 1) increase the reliability and the validity of the QSPR as a measure of practice overall; 2) assure strong inter-rater reliability for the tool within the QSPR review team; 3) Build the capacity of the QSPR team by expanding the number of staff and partners trained in the QSPR process; and 4) strengthen the way in which the QSPR is utilized to guide practice improvements in the field at caseworker, county, Area, and State levels. We will begin to collect data for the baseline in the second quarter and submit our baseline no later than the fourth quarter.

This work will be initiated with internal practice development consultation based on the principles for practice guiding the CFSR, and knowledge of family centered best practice with the core QSPR team – as well as with the initial group of additional staff to be trained in the QSPR. This will have the effect working towards the goals indicated above, and it will provide an opportunity to bring into alignment current drafts of our practice model material with the QSPR and the CFSR.

The next stage of this work will consist of training and consultation with a CFSR case review expert to deepen the training and understanding of the process of reviewing for best practice. This will be an opportunity to develop our baseline yes, but also to begin the communications campaign with key staff and trainers necessary to move the practice model, and indeed the whole PIP forward.

This stage then will be further enhanced with direct training from Regional Office staff on a set of Children’s Bureau approved AR cases – possibly drawing on cases used in the recent CFSR – to assure the validity and reliability of the

QSPR to establish our baseline, and make the quality service review process a tool for practice improvement statewide.

In 2008 the Quality Service Review Team conducted reviews of 400 cases covering all ten service areas in Arkansas. As a part of this QSPR enhancement process, we will consult with our outside trainers and CFSR experts to determine the optimal number of cases needed to balance the intensive qualitative nature of the case review process with a sample size adequate to provide data for the development of the statewide system.

A retrospective look at four months of past data, and a prospective look at eight months of new data, will be utilized to construct our baseline.

C. Measurement of QSPR Data

The QSPR will determine how children and their families benefit from the services they receive. Each review, which focuses on a single DCFS Area, will be conducted within an intensive one-week period. The QSPR will shift the focus away from compliance and quantitative measures and toward the areas of practice, results and qualitative concerns. Reviewers will have access to quantitative information obtained through Arkansas Children’s Reporting and Information System (CHRIS) electronic case record prior to the on-site qualitative reviews and will interview relevant family and collateral contacts needed to make accurate judgments about the quality of individual cases.

QSPR case reviewers will consist of QA Unit staff who do not have direct involvement in the cases being reviewed, additional DCFS staff, and other partners to the process.

Quality Services Peer Reviews will be accomplished through a coordinated effort between the Central Office Quality Assurance Manager and the DCFS Area Managers. Each of the ten Areas will have a least 20 cases selected for review to include 10 In-Home and 10 Out of Home cases. Area 6, Pulaski County, will have reviews conducted every six months, consisting of 20 cases for each review. The case sample for the review will be stratified to assure that all appropriate case types and items will be reviewed.

Currently, the QSPR for 2009 will follow the schedule below.

Review Month	Area to be Reviewed
February	8
March	9
April	2
May	3
June	7
July	6
August	1
September	5

October	4
November	10
December	6*

** 40 cases will be reviewed in Area 6 in 2009 – 20 in July and 20 in December.*

The QSPR Review schedule for 2010.

Review Month	Area to be Reviewed
February	8
March	9
April	2
May	3
June	7
July	6
August	1
September	5
October	4
November	10
December	6*

This will accomplish our measurement objectives for CFSR items under review in the PIP.