

**Bureau of Milwaukee
Child Welfare**

**Health and Safety Review
Report**

September 14, 2009

2009 Health and Safety Review Report

Table of Contents

Introduction	Page 1
Methodology	Page 2
Health and Safety Review Findings	Page 3
Medical Review Findings	Page 3
• Child Protection Center Providers	Page 4
• Clinic Attendance	Page 4
• Reports to 220-SAFE	Page 4
• Onsite Medical Record and Case Practice Review	Page 5
• Medical Follow-up Process	Page 6
Case Practice Review Findings	Page 7
• Qualitative Review	Page 8
• Case Practice Review Follow-up	Page 8
Lessons Learned and BMCW Action Steps	Page 10
• Health Care	Page 10
• Dental Care	Page 12
• Birth to 3 Services	Page 12
• Kinship Care Homes	Page 13
• Safety In Placement	Page 15
• CPS and Health Care Professionals	Page 16
• Caseworker Contact	Page 16
Appendices	Page 18

Introduction

In response to the November 2008 death of one year old Christopher Thomas Jr. who was killed while in a court-ordered kinship placement, Reggie Bicha, Secretary of the Wisconsin Department of Children and Families, directed Department staff to conduct a safety evaluation of children in out-of-home care who are in the custody of the Bureau of Milwaukee Child Welfare (BMCW) and placed in foster or relative care.

The focus of the review was children ages five and under who had been in their current out-of-home placement for 10 months or less as of December 1, 2008. This focus was based on the fact that infants and young children are more likely to be at risk for undetected child abuse and neglect because they are not observed by the range of community members - such as teachers and neighbors - that school age children interact with on a regular basis. In addition, the ways in which infants and young children articulate and communicate their needs are less easily observed, as speech and language skills are in the developmental and emerging stages. Finally, the stakes are high for this group of children due to the long-term impact of their environment on their health and development.

The goals of the review were to:

- Assure that children in kinship or foster care placements are safe;
- Confirm that these children were not victims of repeat child maltreatment while in our care;
- Identify specific case practice and systemic improvements needed to ensure that children in our care are safe and that caregivers receive supports necessary to care for these children.

The safety evaluation consisted of a medical evaluation and a case practice review. The medical evaluation consisted of a specialized health assessment that focused on indicators of child maltreatment; it was conducted by health care providers from the Child Protection Center (CPC), a member of Children's Hospital and Health Care System.

The case practice review employed a point in time evaluation - reviewers made one home visit for each child placed in care, with the caregiver and case manager present. The case practice review team included Area Administration staff from the Department of Children & Families and the Department of Health Services, Quality Service Review (QSR) peer reviewers from counties outside Milwaukee, DCF child welfare program staff, and the BMCW nurse practitioner. Reviewers employed a case practice review protocol that considered the eWiSACWIS and paper case records, and included interviews with case managers and licensing workers. Individual profiles were completed for each child in the review using all information sources to make decisions about child safety. The review process also identified areas that needed follow-up by the case manager or licensing worker.

The information from the comprehensive review was used to 1) determine that the child was safe from immediate harm, 2) assess the impact of any behaviors or needs of other children in the home on the focus child, and 3) determine the ability of the provider to meet the child's current and longer term physical, emotional, and developmental needs.

The findings and key learning opportunities described in this report are based on these reviews.

An important caution - because review findings are based on point-in-time information, they should not be interpreted to mean that ongoing evaluation of child safety is not needed. Continually assessing and confirming the safety of children in relative and foster care homes is the responsibility of the BMCW.

Methodology

A point in time approach was employed to identify children for inclusion in this review, since they enter or are discharged from out-of-home care on an ongoing basis. When a child is placed in out-of-home care, his or her case is formally reviewed by the court every twelve months. This process includes evaluating the safety of the placement. To avoid replicating the court process, this review focused on children five and under who were in their current foster or kinship care home less than 10 months as of December 1, 2008. On that date, the BMCW had a total of 560 children who fit the review criteria. 369 (65.9%) were managed by Children's Family and Community Partnerships (CFCP), 183 were managed by La Causa (32.7%) and 8 (1.4%) were managed by Children's Service Society of Wisconsin.

The out-of-home care safety evaluation consisted of both a medical evaluation and a case practice review. The Department of Children and Families (DCF) and Children's Hospital and Health System developed a specialized medical evaluation, focusing on indicators of child abuse. This evaluation protocol was used to assess any immediate medical needs as well as identify any unmet medical needs requiring attention or follow-up. (See Appendix 1) All suspicions of child maltreatment were reported to 220-SAFE for prompt screening and, when warranted, an initial assessment response. All 560 children received a medical evaluation; of these, 503 also received a case practice review.

The case practice review followed the medical evaluation. State and contracted agency staff from the BMCW as well as child welfare program staff from the Department of Children and Families collaborated to develop the onsite review process, using state policies and portions of the Quality Service Review protocol to create a Milwaukee Case Practice Review Profile tool to support and document reviewers' decisions about child safety in foster and kinship care placements. (See Appendix 2 and Appendix 3) The onsite reviews started in January of 2009 and concluded in March of 2009. Additional cases were reviewed in April of 2009 for children placed outside of a 60 mile radius from Milwaukee. Onsite consultation was available to the review team to discuss case dynamics, interpret state policy, answer health care questions, and participate in cases staffings with case managers and supervisors.

The "Milwaukee Provider Home Background Checks and Study Review" tool (See Appendix 4) was developed to evaluate the foster home licensing files from Children's Service Society of Wisconsin (CSSW). The background check information for individuals in the foster home as well as information about the foster parent's history and parenting practices was then provided to reviewers to assist in understanding provider strengths and needs. This licensing information, the medical evaluation, and the kinship care referral and background check information were provided to the review team to further assist in confirming the safety of placement.

At each BMCW Region, the onsite review started with an entrance meeting with all staff to provide an overview of the process and respond to questions. During the review process, supervisors and managers were invited to participate in debriefings to discuss case practice strengths and areas needing improvement. At the conclusion of the review at each Region, an exit meeting was held with all staff to provide general information about the findings and identified issues.

The review team evaluated each case by:

- reviewing the background check information for foster care and kinship care providers;
- reviewing the BMCW case record for the child;
- reviewing the results of the medical evaluation and other available medical records;
- interviewing case managers and supervisors;
- interviewing the licensing worker, as appropriate;
- consulting with the BMCW nurse practitioner; and
- conducting home visits with the foster care or relative providers, the child, and the case manager.

Based on this information, a Milwaukee Case Practice Review Profile was completed for each child. Reviewers evaluated and made determinations about child and caregiver strengths and needs as well as about case practice in order to confirm the safety of the placement. At the conclusion of the review, profiles were shared with the case manager and supervisor that provided recommendations to improve case practice.

Health and Safety Review Findings

Medical Review Findings

The first component of the review process was for each child to receive a physical examination by specially trained health care providers. The process recognized that the health care needs of children involved with the child welfare system are unique when compared to those of the general population. Due to the history of abuse or neglect that usually precedes an out-of-home placement, children in foster care often exhibit higher than average levels of developmental delay, chronic medical and dental conditions, and behavioral issues.

An appropriate health assessment enhances the capacity for each child to thrive and achieve his or her maximum potential. It provides opportunities to reduce caregiver stress by providing guidance and education to assist in understanding the health and wellness needs of children in their care. Health assessment information also assists case managers in making placement and permanency decisions.¹

Safety in placement was the overarching goal of the health evaluations. Providing for and ensuring that children in out-of-home care receive appropriate services to identify, treat, and monitor health needs is fundamental to meeting their needs for safety, permanence, and well-being. While a lack of

¹ Children entering out-of-home care in Milwaukee are required to receive a health assessment within five days of entering care and have an appointment scheduled for a more thorough medical evaluation through the Medicaid HealthCheck program within 30 days.

routine health services does not mean a child is unsafe, the information gathered during these well-child visits promotes healthy growth and development and also helps foster and kinship care providers understand and meet the needs of the children in their care.

Child Protection Center Health Care Providers

The Child Protection Center (CPC), a member of Children's Hospital and Health Care System, coordinated the medical portion of the review ² given their expertise necessary in the assessment of signs of abuse or neglect and ability to address routine health care needs. The CPC staff facilitated and coordinated the medical evaluation process, conducted specialized in-service training to the Urgent Care medical provider participants, and provided expert consultative services as key partners in this endeavor. CPC staff, along with selected health care providers in the Milwaukee community, established a series of clinics from December 2008 to March 2009 for conducting the medical evaluations.

Clinic Attendance

Case Managers, or their designees, scheduled the evaluation, transported the child, and typically attended the appointment with the child. Transportation by the case manager was required in the event signs of abuse were discovered and a child needed to be detained at the clinic site. This also provided an opportunity for observation, age appropriate discussion, and interaction between case managers and the children. Kinship and foster care providers, who were encouraged to attend the evaluation, were consulted about the child's medical history, day-to-day activities, and routines.

Reports to 220-SAFE

When CPS receives a report of alleged child maltreatment or threatened harm, current or previous information about a child and their family is used to screen the report. For screened in reports, this information is also used to determine the agency's response time to begin an initial assessment (investigation), evaluate child safety, and make a determination whether the child was maltreated.

The authority to conduct an initial assessment (investigation) extends only to those cases where the report provides information that a child may be subject to or threatened with maltreatment. A report is screened out only after the totality of case information and circumstances is assessed and the agency determines CPS intervention is not warranted.

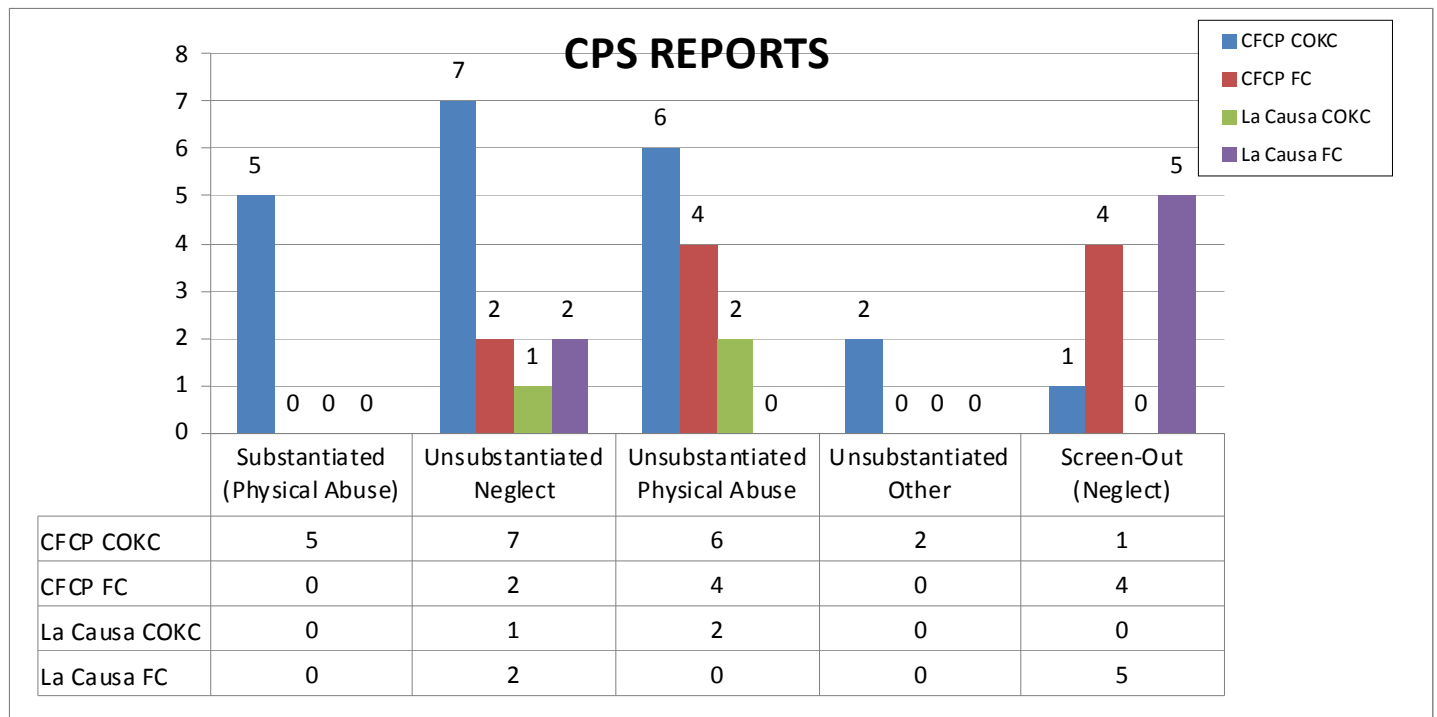
The medical evaluations resulted in forty reports of alleged maltreatment, involving 41 children. Seventy-five percent (75% or 30) of these reports were screened in for a CPS response. Of the 30 reports screened in, five (17%) were substantiated for physical abuse. All were in court-ordered kinship care at the time; in all five instances, the kinship care provider was not the maltreater. (Graph 1 provides further information.) Two children remained in their current placement while 3 children were moved to another home due to changing dynamics or conditions in the relative's homes.

² This information is documented on the Out-of-Home Safety Evaluation Form in Appendix 1. Also included in this appendix is a description of the components of the medical evaluation.

Staff from the Bureau of Safety and Well-Being and the Bureau of Milwaukee Child Welfare reviewed all cases with an unsubstantiated finding. As a result, priority staffings occurred for eight cases with BMCW managers and workers to clarify or obtain additional case information. Subsequently, child safety was confirmed in all cases and maltreatment was substantiated in one case.

Additionally, the BMCW screened out 10 CPS reports because there were no threats to child safety. While reported concerns did not warrant a CPS initial assessment, the BMCW nurse practitioner or assigned case manager provided any needed follow-up.

Graph 1



Onsite Medical Record and Case Practice Review

The medical review component of the onsite case review was lead by the BMCW Nurse Practitioner. It included interpreting medical documentation and diagnoses as well as staffing cases with reviewers for medically fragile infants and medically complex children in the target population. The documentation for each medical evaluation was reviewed to determine the need for any additional medical follow-up. This process included:

- plotting the growth parameters, if not already documented, on the safety evaluation forms in order to assess and ensure proper growth and weight gain
- reviewing documentation to assess for findings of dental caries, physical, or developmental concerns that were not subsequently listed in the diagnosis/recommendation section (i.e. treatment of dry skin/eczema, asthma management plans, allergy concerns, etc.)

- selecting diagnoses or concerns that necessitated follow-up by the primary medical/dental provider or specialist (i.e. Otitis media, asthma exacerbation, weight loss, dental caries, heart murmur, gait disturbance, eczema, hernia, urological concern, immunizations, ringworm, speech delay, behavioral problems).

Children who were prescribed antibiotics, bronchodilators, or topical antibiotic, antifungal, or steroid creams at the time of the Out-of -Home Safety Evaluation were also identified for monitoring to assure subsequent follow-up by the primary medical provider.

Medical Follow-up Process

Upon completion of the Out-of -Home Safety Evaluation record review, slightly more than half (305 of 560 children) required some degree of medical follow-up. This ranged from a health record review to confirm immunization status, to an ill child follow-up for acute illness or exacerbation of a chronic condition with the pediatrician, up to a specialty referral for a medical or surgical evaluation. The BMCW nurse practitioner worked with staff at each Region to track and monitor the follow-up of all identified health concerns.

Of the 305 children who needed medical follow-up:

- 73 (24%) were delayed on immunizations. With reminder emails to ongoing case managers, who arranged follow-up with the primary care doctor (PMD), the rate is now <1% for the target population.
- 67 (22%) had dermatological problems identified during the exams. For these children, skin care education was provided individually to ongoing case management staff in order to improve understanding of the need for consistent skin care and moisture maintenance. One child had documented continued skin irritation and further dermatological follow up was obtained.
- 55 (18%) had received prior specialty care services and required a follow-up appointment. It is important to note that these appointments reflect involvement in specialty care prior to the Out-of -Home Safety Evaluation.
- 30 (10%) were referred for specialty care due to a need indentified during the evaluation. Of these, further discussion with the Primary Medical Doctor (PMD) indicated that follow up was not required for four children due to a prior specialty evaluation. The PMD continued to monitor the child's health care needs and planned to re-refer as needed.

Specialty referrals included:

- Cardiology - 10 follow-up appointments and 2 new referrals
- Surgery - 8 follow-up appointments and 4 new referrals
- Ophthalmology- 7 follow-up appointments and 1 new referral
- Ear Nose and Throat - 5 follow-up appointments and 2 new referrals
- Gastrointestinal - 5 follow-up appointments and 4 new referrals
- Genetics – 4 follow-up appointments and 1 new referral
- Neurology - 4 follow-up appointments and 1 new referral
- Urology - 4 new referrals
- Dermatology - 2 follow-up appointments and 4 new referrals
- Cranio facial - 2 follow-up appointments

- Burn clinic - 2 follow-up appointments
- Pulmonary - 2 follow-up appointments and 2 new referrals
- Hematology - 1 follow-up appointment and 1 new referral
- Orthopedics - 1 follow-up appointment and 1 new referral
- Asthma /Allergy - 1 follow-up appointment and 3 new referrals
- Dietician - 1 follow-up appointment and 1 new referral
- Rheumatology - 1 follow-up appointment

In addition, education on common diagnoses, implications for case management, and effects on the overall health and well-being of the child were provided for agency staff who consulted with the nurse practitioner during the review. Where medical issues were identified, targeted education on topics such as asthma management, healthy nutrition, and skin care was provided for case managers specific to children on their caseload. Agency staff were directed to provide or reinforce this information to relative or foster care providers.

The review also provided the opportunity to remind the case manager of the upcoming routine well-child care examinations and immunization administration according to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive and preventive child health program recommendations. Dental appointments for routine examination and preventive cleaning were also recommended at 6 month intervals for all children age 3 and up.

Case Practice Review Findings

The case practice review team evaluated and confirmed the safety of placement for 503 children. Not all of the 560 children who received a medical evaluation were included in the case practice review. Fifty-four children that received a medical evaluation were adopted or reunified during the review process or did not meet the criteria for inclusion in the review. In addition, the case practice review was not completed for three children:

- one child resides out-of-state; and
- two children were in transition to a new placement so the review could not be scheduled.

During the onsite case practice review, no reports of alleged maltreatment were made to the BMCW. Consultation on ten cases resulted in a recommendation to move two sibling groups to another placement setting. These were cases where kinship caregivers stated to reviewers that when they accepted placement they were not aware of how long the children would be with them and that they were no longer able to care for the sibling group.

The following tables reflect the case practice review population:

Table 1

Agency	#	%
CFCP	322	64.0%
La Causa	181	36.0%
Total	503	100.0%

Chart 1

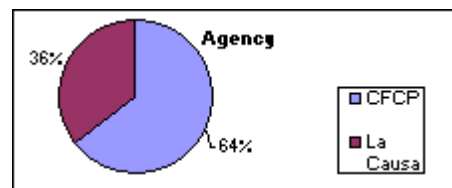
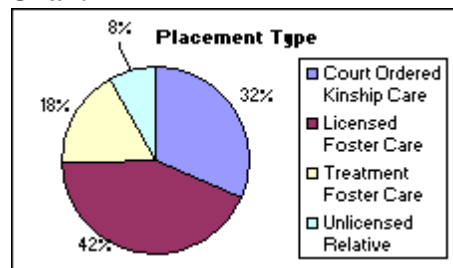


Table 2

Placement Type	#	%
Court Ordered Kinship Care	159	31.6%
Licensed Foster Care	214	42.5%
Treatment Foster Care	89	17.7%
Unlicensed Relative	41	8.2%
Total	503	100.0%

Chart 2

The data in Table 3 demonstrates that a Birth – 3 referral is made in a high percentage of the applicable cases, and that when a developmental delay is identified, Birth to Three provides follow-up services. The challenge, which is discussed in the Key Learning Opportunities section of this report, appears to be related to timely access to evaluation and therapeutic services.

Table 3

Case Practice – Birth to 3	# Applicable Cases	# Yes	% Yes
Birth to 3 referral complete	368	332	90.2%
Birth to 3 assessment complete	332	234	70.5%
Developmental Delay Identified	234	90	38.5%
Birth to 3 follow-up services provided	234	91	38.9%

Qualitative Review

Case reviewers used the Milwaukee Review Protocol to guide decisions about safety in placement and to document case information and feedback for case managers (See Appendix 2). Information gathered through interviews and the case record was used to assess and understand agency case practice and then the protocol was used to support reviewers professional judgment related to:

- the needs of the child (physical, emotional, behavioral, and educational),
- the continued ability of the providers to meet the child’s needs (caregiving capacity),
- the caregiver’s motivation for and understanding of the need for placement,
- the child’s adjustment to the placement and their physical and emotional well-being, and
- the family selection and match and the impact on child safety.

This information translated into scores in two broad areas: Child and Caregiver Status and Practice Performance. For purposes of the review, areas scoring a 1, 2, or 3 meant that some type of follow-up or attention was needed to improve case outcomes

Case Practice Review Follow-up

More than one-third (169 or 34%) of the 503 child cases reviewed required some type of follow-up by case managers. Of these 169 cases, 113 (67%) children were receiving services from CFCP while 56 (33%) children were receiving services from La Causa. This is in roughly the same proportion as each agency’s percentage of children in the target population.

Twenty one percent (103) of the cases involved in the qualitative review process scored a 3 or below in one or more areas. The BMCW quickly followed up to further evaluate these cases to meet the needs of children or their foster or kinship caregivers. While a score of 3 or below does not indicate that a child is unsafe, it does indicate that the case manager needs to further evaluate case dynamics in order to understand the child’s needs and the ability of the caregivers to meet those needs. If a child evidences needs that the caregiver cannot or refuses to meet, the child’s safety comes into question.

Table 4 provides examples of child status measures, caregiver status measures and practice performance measures. It is important to note that three percent of children evaluated (16) had scores of 3 or below in more than one area.

Table 4

Category	# Applicable Cases	# Cases 3 or below	% Cases 3 or below
Child Status			
Physical Health	503	9	1.8%
Emotional Development*	222	20	9.0%
Behavioral Function *	220	28	12.7%
Caregiver Status			
Caregiving Capacity	503	16	3.2%
Basic Necessities	503	9	1.8%
Practice Performance			
Family Selection	503	25	5.0%
Adjustment	503	12	2.4%

* These indicators were only used for children aged 3 and over

An additional 66 cases (13%) were identified by reviewers as needing follow-up due to other case practice concerns. These primarily focused on:

- 1) obtaining Birth to 3 evaluations or services;
- 2) obtaining and monitoring therapeutic services for emotional, behavioral, developmental or early learning needs;
- 3) conducting a thorough assessment of kinship care homes in order to understand family dynamics, strengths and needs.

Feedback was provided to CSSW regarding needed follow-up on foster home licensing files and case practice. Two cases required prompt attention by CSSW; one involved the layout of the home and the accessibility between the first and second floors and the other involved a commercially sold device that needed to be removed from a child’s crib since the device is not allowed by Wisconsin Administrative Code DCF 56, “Foster Home Care for Children.” Other necessary follow-up related primarily to updating the foster home licensing file (e.g. HFS 56 checklist, documentation, etc.) and providing support and identifying community resources for caregivers in order to meet the needs of the child placed in their home.

A Program Evaluation Manager with the BMCW and a Section Manager with DSP collaborated with staff at each Region and at CSSW to develop a process to track and monitor the follow-up of all

identified case practice and licensing concerns. The Program Evaluation Manager monitored the process and worked collaboratively with case managers and other agency staff to resolve all case issues by June 2, 2009.

Lessons Learned and BMCW Action Steps

The 2009 Milwaukee Out-of-Home Safety Evaluation review provides opportunities for the BMCW and the Milwaukee community to improve supports and services for children placed in out-of-home care as well as their relative or foster care providers. The identified key learning opportunities and potential strategies and action steps do not mean that children were unsafe during the review. Rather, these are areas that may require further focus to assist case managers and caregivers to better identify, understand and be able to meet the unique needs of children placed in out-of-home care.

1. Health Care

The medical portion of this review was designed to provide a point-in-time evaluation to assess for signs of maltreatment for the most vulnerable children in foster or kinship care. This process also provided an opportunity to gain better awareness of the medical and dental needs of this population.

The availability of a health care professional to interpret and explain the medical conditions and concerns, as well as answer questions during the onsite review was beneficial to the state reviewers and case managers. Social workers typically have little health care experience and therefore do not have the necessary knowledge and understanding of medical issues and their potential or actual impact on the health and well-being of children. Having a readily accessible health care resource encouraged professional curiosity and robust discussion with the reviewers and ongoing case management staff. This brought clarity and improved awareness to common concerns and potential threats to safety if identified health conditions were left unaddressed or untreated.

The health care needs of children involved with the child welfare system are more significant when compared to those of the general population. In addition to a possible lack of attention to overall health care needs, the history of abuse and neglect that usually precedes an out-of-home placement contributes to a child's higher than average level of developmental delay, chronic medical and dental conditions, and behavioral concerns. These issues directly relate to the child's increased level of vulnerability and the capacity of the caregiver to meet the child's physical and behavioral health needs.

The complexity of the health needs of many children in out-of-home care requires coordination of an array of services, often delivered through multiple providers. Ensuring the identification of medical, dental, developmental and mental health needs of children entering foster care is the critical first step in establishing an appropriate plan of care.

The 30-day Comprehensive Health Assessment, required for all children in out-of-home care, is a well-child assessment and evaluation. At this appointment, a child's health care needs and developmental milestones are fully evaluated in order to provide routine and preventive care. Many case managers, however, were either not aware this assessment is required or did not understand its purpose or value. In order to assure that the health status of children entering out-of-home care is

evaluated in a timely manner, the BMCW should educate case managers as well as kinship and foster care providers about the purpose and importance of the 30-day comprehensive exam, as well as ongoing periodic well-child care.

Understanding the purpose of periodic well-child health checks by BMCW case managers was noted to be an issue throughout the review. Since childhood is a time of rapid growth and change, the goal of well-child health checks is to determine whether a child's needs at different ages, stages, and periods of growth are being identified and met. These assessments also provide caregivers with guidance and education to assist in understanding the health and developmental needs of children in their care.

Barriers and gaps in the delivery of health care services for children in out-of-home care were identified and need to be addressed at the systems level, especially as it relates to access to and quality of care. Identifying and addressing system-level concerns by health care providers and the child welfare system requires further assessment of health data, health education needs, and available resources within the community. A logical next step would be to use the findings of this review as the foundation for creating a comprehensive health care framework for children in out-of-home care served by the Bureau of Milwaukee Child Welfare.

BMCW Action Steps

The BMCW continues to improve communication and understanding of the health needs of children in out-of-home care both internally and between the agency and its community health care providers.

Efforts include:

Integrating additional health care consultants

- ◆ The BMCW is already exploring ways that health care consultants will assist staff and out-of-home care providers in identifying, understanding, and responding to children's health care needs.
- ◆ Governor Jim Doyle's 2009-11 biennial budget supports these activities by allocating funds to contract professional health service providers to help monitor the health of children in out-of-home care placements in Milwaukee.

Education and monitoring

- Increase awareness of the importance of well-child exams, as well as dental, developmental, and mental health services to support healthy development. Special emphasis will be placed on obtaining past medical history and current health status of children entering out-of-home care.
- Educate staff as to the importance of the 30 Day Health Check exam and how this provides essential information regarding a child's health status, which is an integral component of case planning.

- Emphasize the importance of documenting, updating, and managing medical, dental and mental health information in eWiSACWIS. Pursue strategies identified by the Healthy Wisconsin Partnership Grant on The Medically Fragile Foster Child in order to address identified issues and barriers for children with special health care needs in foster care through education and community linkage across medical, legal, and child welfare systems.

Statewide, the Child Welfare Training Partnerships are exploring development of curriculum directed at understanding the medical, dental, developmental and mental health needs of children in out-of-home care.

2. *Dental Care*

The American Academy of Pediatric Dentistry (AAPD) recommends dental examinations and teeth cleaning every six months beginning at 12 months of age or 6 months after the first tooth erupts. Accessibility and timeliness of follow-up was noted to be an issue in regard to dental care. There is an acknowledged lack of dental providers in the Milwaukee area, particularly pediatric dental providers who also accept Medical Assistance.

Tooth decay, even in the earliest stages of life, can have serious implications for a child's long-term health and well-being. The discovery of dental caries in a child who has not regularly practiced good oral hygiene and has experienced a lack of adequate nutrition is not unusual, but may lead to significant complications (e.g., local and systemic infection, abscess, and pain with eating leading to weight loss or behavioral issues at mealtimes, etc.). It may take several months to obtain an appointment for routine dental care for children under three years of age or for children who require specialty dental care, such as endodontic or sedation dentistry for severe dental disease, emotional problems, anxiety, or developmental delay.

BMCW Action Steps

- Utilize the Mobile Dentist to provide timely general dental care.
- Explore the option of developing a readily accessible network of general and specialty dental providers within the community to improve access to dental care for children in out-of-home care.
- Increasing staff awareness of the importance and relationship between dental health and physical health, as well as reflecting the AAPD recommended dental periodicity.

3. *Birth-to-3 Services*

The Child Abuse Prevention and Treatment Act (CAPTA) requires the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to the Birth-to-3 program. Since maltreatment impacts the development of infants and children, the purpose of this requirement is to identify developmental and social-emotional delays in order to provide targeted early intervention services.

A birth-to-3 evaluation assists caregivers in understanding the developmental needs of children placed in their care. This information is also useful for agency staff in assuring the caregiver has the willingness and capacity to meet the identified needs.

Timely access to evaluation and therapeutic services through the Birth-to-3 program is an area that needs further exploration. Developmental screenings are often performed over the telephone, within a few days of placement. The accuracy of the screening results may be compromised if the evaluator does not observe or interact with the child. The care provider may be unaware of the early signs of developmental delay or may be unwilling to acknowledge a deviation from normal growth and development in an attempt to normalize the child. A telephone screening of children in out-of-home care relies heavily on the care provider to give an accurate account of a child's level of development without having a basis for comparison or an awareness of the health history that potentially impacts the child's development. Resources for Birth-to-3 are acknowledged to be limited, so this review indicates a need to evaluate the screening and evaluation practices in regard to the child welfare population.

In order for the BMCW and the Birth-to-3 program to be more effective, both systems should explore ways to improve needs assessment and service delivery. This includes, but is not limited to, discussing issues about the timing of referrals to Birth-to-3 (especially since there is no specified timeframe in CAPTA to make the referral), providing cross system education, and meeting on a regular basis to focus on barriers and solutions in providing timely services to children and their caregivers.

BMCW Action Steps

BMCW and Birth-to-3 leadership will engage in discussion to assess the referral process and prioritize the timely implementation of services specific to the most vulnerable within the out-of-home care population.

4. Kinship Care Homes

Court-ordered kinship care is a placement option that allows a child to reside with a relative when they cannot remain safely in their own home. In June 2009 in Wisconsin, 1,398 children were placed in court ordered kinship. This comprises 20.43% of the children placed in out-of-home care for that month.

Currently, the kinship care program is guided by administrative rule DCF 58, while the foster care program is guided by DCF 56. The requirements for becoming a kinship care provider are less rigorous and there is no expectation for training to prepare and support the provider in the caregiving role. The foster care licensing process has a more extensive background check process and there is a training requirement.

It is important to note that current research indicates that kinship care is the fastest growing placement type nationally. Additionally research finds that the supportive service needs of kinship care providers are greater than those of foster care providers.

Findings from the onsite case practice review indicate a need for the BMCW to reassess the process for screening and assessing kinship care homes. Staff need a clearer understanding of kinship care assessment and approval process and the annual reassessment and background check of kinship care homes. There appears to be confusion about how information is shared among the agency conducting the background check, the agency conducting the unlicensed caregiver placement evaluation, and the agency providing ongoing case management services.

Reasonable next steps to assess safety in placement and to assure all involved are knowledgeable about family and case dynamics would be to focus efforts on:

- 1) streamlining this process and reducing the number of staff involved in evaluating and managing the kinship care homes,
- 2) using the foster care process to evaluate kinship care homes, and
- 3) requiring the same training for court ordered kinship care and foster care providers.

Reviewers noted that kinship care providers typically did not receive the same supports and services as foster care providers. Foster parents seek out an agency to license, train, and prepare them to accept children in their home. Relatives, on the other hand, usually have little preparation for a placement or understanding of the child welfare system and available resources when they step in to care for children in order to avoid having them placed in the “system.” The findings of this review present the BMCW with an opportunity to host focus groups or engage kinship care providers in conversations to gather information about and provide needed supports to relatives.

BMCW Action Steps

The BMCW has initiated and will continue to engage in activities that strengthen the assessment process of kinship care homes and provide needed supports to kinship care providers. These include:

1. Expanding the capacity of CSSW by adding relative provider coordinators to assist case managers in providing support to unlicensed relatives, including helping to remove any barriers to licensing.
2. Expanding Mobile Urgent Treatment Team (MUTT) services to support kinship care providers in coping with children’s behavioral or mental health issues in times of crisis.
3. Implementing the levels of care foster care licensing initiative to provide training and increased support for relative providers. This will include information about resources and supports available to them as care providers, as well as how to better interact with and navigate the child welfare system.
4. Reviewing the process for screening and reviewing kinship homes. Strategies to ensure comprehensive, systematic oversight and quality assurance are being developed. Any changes made in the unlicensed caregiver provider assessment procedure will be done in tandem with the new levels of care licensing standards scheduled for implementation in January 2010.

5. Safety in Placement

The Adoption and Safe Families Act as well as the Child Protective Services Safety Intervention Standards require that child welfare staff evaluate the safety of a foster or kinship care home when a child is first placed in the home as well as confirm the safety of the placement at six month intervals. State policy provides agency staff with criteria to make these determinations in both licensed and unlicensed homes.

Greater focus should be placed on the purpose, criteria, and process for routinely assessing and confirming safety in kinship and foster care placements. In the absence of clear direction, staff rely on evaluating the physical safety of the placement setting (e.g., smoke alarms, number of beds, etc.) rather than assessing and understanding caregiver perceptions and behaviors related to the specific needs of the children placed in their home. Next steps should include training specific to assessing and confirming safety in placement and developing an internal staffing process to support staff decision-making.

The findings of the review indicate that at any given time, out-of-home caregivers interact with more than one case manager. Case visits focus on the specific child on their caseload, rather than on all of the children in the home. Reviewers felt that without some type of formal communication among case managers who have children placed in the same home, conditions and dynamics related to safety may not be fully understood. In these circumstances, the BMCW should consider instituting a monthly staffing process to discuss each child's needs and progress; the impact of any child's behaviors on other children in the home; and the ability of the caregiver(s) to meet the needs of all children placed in their home.

BMCW Action Steps

In addressing safety in out-of-home care:

- The BMCW is implementing a safety intervention system focusing on child safety throughout the time a child is in care. Efforts to structure and systematize home visit activities and processes have been put in place and the need to further review these activities and processes identified. Efforts to unify the safety assessment approach making it criteria-based, family-centered, and sufficiently focused on safety evaluation in kinship care are underway.
- The BMCW training team supervisors in conjunction with the Milwaukee Child Welfare Training Partnership will develop a training protocol to help improve consistency in assessing safety in out-of-home care. In addition, the current monthly supervisory protocols will be re-tooled to ensure that the supervisor and case manager review and discuss each child's needs and progress; the impact of any other child's behavior in the home; the protective capacity of relative providers; and the ability of the caregivers to meet the needs of all children placed in their home.

6. CPS and Health Care Professionals

Health care professionals have expertise to assist CPS in making determinations about whether injuries are consistent with the history and developmental abilities of the child. Collaboration between CPS and health care professionals increases the thoroughness and accuracy of information to make critical decisions about child safety.

In order to further understand the needs of children placed in out-of-home care, the BMCW should continue its efforts to enhance communication and follow up with medical providers by initial assessment and ongoing services staff. The BMCW should develop a protocol with the Child Protection Center (CPC) in order to more effectively collaborate in the response to cases of child maltreatment. This information supports safety decision-making by clarifying the significance of medical findings.

BMCW Action Steps

In order to protect children and improve their safety, efficiently and effectively gather information for purposes of assessment and reduce trauma to children, the staff from the BMCW and the CPC will review and revise the existing protocol to enhance cross agency communication and collaboration.

Systems collaboration:

- “Same Day” CPC Health Screening appointments are available for all children at the time they are taken into temporary physical custody. A walk-in appointment may be arranged by the detaining worker while en-route to CPC. Identified health concerns and recommended follow-up will be discussed with the Initial Assessment social worker at the conclusion of the CPC Health Screen. Identified needs and the plan for follow-up will be discussed during the IA to Ongoing Case Transfer staffing.
- The BMCW will revise the 35 day Coordinated Services Team protocol to clearly identify and reflect a plan to address routine and special health care needs identified in the CPC Health Screen. In addition, at the 35 day CST, case managers will confirm that the required 30-day comprehensive Health Assessment has been completed and will incorporate any recommendations for medical, dental, developmental or mental health care into the case management plan.

7. Caseworker Contact

Child safety is the paramount concern guiding the requirements for a CPS ongoing case manager’s face-to-face contact with children and foster and kinship care providers. Consistent face-to-face contact is necessary to engage children and caregivers and build a trusting, working partnership in order to directly impact positive outcomes for children, including the safety, timely achievement of permanence, and improved well-being.

The BMCW, similar to counties across the state, has policy regarding the frequency of caseworker contact with children in out-of-home care. While the BMCW policy requires twice a month contact for children ages 3 and under and for all medically fragile children, the contact policy is lacking specific guidance related to casework activities that are based on the developmental age of the child. Reviewers noted that absent specific direction, case managers are left on their own to determine the content of their visits with children and their caregivers. The BMCW should update its policy to provide specific focus on the child's safety and permanency needs. Additionally, the policy should outline the case manager's role in visits with children by providing age specific information about child developmental tasks and examples of corresponding casework activities.

BMCW Action Steps

BMCW recognizes the need to provide more guidance in what should occur during a case manager's visit with a child to ensure the visit assesses safety and well-being in context of the developmental stages of the child. BMCW will provide case managers with growth and development guidelines to assist with their interaction with children in out-of-home care. BMCW has identified a pocket guide and is in the process of assessing availability and cost. Using the guide during case visits will be part of case manager training.

Conclusion

The 2009 Milwaukee Out-of-Home Care Safety Evaluation found that children included in the review were safe in their foster or kinship care homes. These findings reflect a high degree of professionalism and commitment to families among staff from CFCP, La Causa, CSSW, and the BMCW. Reviewers found that staff were engaged with children and caregivers and worked hard to understand and help meet their needs.

While attention may be focused on the substantiations of physical abuse, this review confirms that the most vulnerable of our child welfare population have been placed in homes determined to be safe, and that our ongoing case managers are working very hard to ensure that they remain safe. A quote from the well-respected child welfare advocate John Mattingly back in 1999 best describes this experience, "The most visible and powerful incidents of child abuse are a tiny and unrepresentative part of the much larger universe of child welfare cases."

Although this review confirms that good work is being done on a daily basis, it identifies challenges and practice issues that need to be addressed to improve services and supports for children and their caregivers. Collaboration among agency and community partners is paramount as the BMCW strives to refine the system in order to assure children are safe and protected. The lessons learned identified in this report allow us to take measured steps to systemic improvement, and should be considered a product of a continuous quality improvement process.

The Out-of-Home Safety Medical Evaluation

The Safety Medical Evaluation provided a:

- review of available medical and developmental history
- review of biological systems
- conduction of a thorough physical exam to assess for and document lesions, birthmarks, injuries, scarring or other dermatological conditions
- assessment and growth chart plotting of height, weight, and age appropriate head circumference
- monitoring of temperature, pulse and age appropriate blood pressure
- identification of acute or chronic medical conditions
- identification of suspected developmental delay
- appropriate treatment for assessed conditions
- age appropriate health education and guidance for care providers and children as applicable

Referrals were made for further diagnosis and treatment or follow up of any abnormalities which were treatable, correctable through medical specialty care, or required maintenance care such as behavioral, physical/occupational, or speech therapy.



Children's Hospital
and Health System™

Out-of-home Care
Safety Evaluation

PATIENT NAME :
RN :
DOB :
DOS :

Patient Label

Patient was been previously seen at Child Protection Center (CPC)? <input type="checkbox"/> Not known <input type="checkbox"/> NO <input type="checkbox"/> YES Date:									
Ongoing Case Manager (OCM):			Child brought in for exam by: Name/Relation			Child Lives With: Relation			
CONSULT REQUESTED BY: Department of Children and Families			CURRENT PMD:			DDS:			
Last Medical Exam if known: Date:			Last Dental Exam if known: Date:			Last visit with biologic parent(s), if known: Date: Supervised: <input type="checkbox"/> NO <input type="checkbox"/> YES By:			
Temp:	Pulse:	Resp:	BP:	POX:	PAIN: /10	Immunizations: <input type="checkbox"/> Documented Up To Date UTD <input type="checkbox"/> Documented Not UTD <input type="checkbox"/> Not known			
Do Not Correct Growth Parameters for Gestational Age.	Height/Length: Cm %		Weight: Kg %		Head Circumference: Cm %		Vitals done by:		
Reason for PLACEMENT/DETENTION: <input type="checkbox"/> Neglect: <input type="checkbox"/> Medical <input type="checkbox"/> General <input type="checkbox"/> Abuse: <input type="checkbox"/> Physical <input type="checkbox"/> Sexual									
Reason for Consult/Chief Complaint: Evaluation for evidence of neglect or abuse. <input type="checkbox"/> Other: _____									
History of Present Illness:									
<div style="border: 2px solid black; padding: 10px; width: fit-content; margin: auto;">DRAFT: NOT FOR ACTUAL USE</div>									
ALLERGIES (List Allergen and Reaction):								<input type="checkbox"/> No Known Allergies	
MEDICATIONS: <input type="checkbox"/> No Medications									
_____ <input type="checkbox"/> Rx <input type="checkbox"/> OTC Currently using: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Out of Medication									
_____ <input type="checkbox"/> Rx <input type="checkbox"/> OTC Currently using: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Out of Medication									
_____ <input type="checkbox"/> Rx <input type="checkbox"/> OTC Currently using: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Out of Medication									
_____ <input type="checkbox"/> Rx <input type="checkbox"/> OTC Currently using: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Out of Medication									
<input checked="" type="checkbox"/> Family History not obtained due to out-of-home placement.									
PMH/SOCIAL HISTORY: N0: YES: COMMENTS:									
Hospitalizations/ Surgeries:			<input type="checkbox"/>		<input type="checkbox"/>				
Health Problems:			<input type="checkbox"/>		<input type="checkbox"/>				
Nutrition:			<input type="checkbox"/>		<input type="checkbox"/>				
Sleep:			<input type="checkbox"/>		<input type="checkbox"/>				
Elimination:			<input type="checkbox"/>		<input type="checkbox"/>				
Daycare:			<input type="checkbox"/>		<input type="checkbox"/>				
Ages of Other Children in current Home:				Biological:			Foster:		
REVIEW OF SYSTEMS:				NEG POS				NEG POS	
Weight Loss				<input type="checkbox"/>		<input type="checkbox"/>		Musc/Skel: Limp, Weight Bearing <input type="checkbox"/>	
Fevers				<input type="checkbox"/>		<input type="checkbox"/>		Skin: Bruises, Swelling, Rashes, Eczema <input type="checkbox"/>	
Eyes: Drainage, Abnormal Movements				<input type="checkbox"/>		<input type="checkbox"/>		Neurological: Seizures <input type="checkbox"/>	
ENT: Ear Pain, Throat Pain, Rhinorrhea				<input type="checkbox"/>		<input type="checkbox"/>		Psychiatric: Acting Out <input type="checkbox"/>	

Dental: Caries, Tooth Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heme: Bleeding, Anemia, ↑Lead	<input type="checkbox"/>	<input type="checkbox"/>
Cardio: Cyanosis, Sweating while eating	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Reactions	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory, URI, Wheeze, Cough, Distress	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional Injury (Accidents):	<input type="checkbox"/>	<input type="checkbox"/>
GI: Vomiting, Diarrhea, Feeding Vigor	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

Describe all positive findings not in HPI:

PHYSICAL EXAM: WELL NOURISHED/CLEAN:
Yes No

GENERAL: Active Happy Playful Engaged Withdrawn
Delayed

Movements: Rolls Over Sits Crawls Cruises Walks

Vocalizations: None Coos Babbles 2-3 Words 8-10 Words
10+

PT NAME :
RN :
DOB :
DOS :
Patient Label

	NL:	ABN:	DOCUMENT ALL SIGNIFICANT FINDINGS:
EYES: Conjugate Gaze	<input type="checkbox"/>	<input type="checkbox"/>	DRAFT: NOT FOR ACTUAL USE
EOMI	<input type="checkbox"/>	<input type="checkbox"/>	
PERRLA	<input type="checkbox"/>	<input type="checkbox"/>	
Conjunctiva	<input type="checkbox"/>	<input type="checkbox"/>	
EARS: Shape and location	<input type="checkbox"/>	<input type="checkbox"/>	
Pinna: Anterior	<input type="checkbox"/>	<input type="checkbox"/>	
Pinna: Posterior	<input type="checkbox"/>	<input type="checkbox"/>	
Canal	<input type="checkbox"/>	<input type="checkbox"/>	
TM	<input type="checkbox"/>	<input type="checkbox"/>	
NOSE:	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH: Oral Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	
Upper Labial Frenulum	<input type="checkbox"/>	<input type="checkbox"/>	
Lower Labial Frenulum	<input type="checkbox"/>	<input type="checkbox"/>	
Lingular Frenulum	<input type="checkbox"/>	<input type="checkbox"/>	
Buccal Mucosa:	<input type="checkbox"/>	<input type="checkbox"/>	
Dentition, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	
THROAT:	<input type="checkbox"/>	<input type="checkbox"/>	
NODES:	<input type="checkbox"/>	<input type="checkbox"/>	
LUNGS:	<input type="checkbox"/>	<input type="checkbox"/>	
HEART:	<input type="checkbox"/>	<input type="checkbox"/>	
ABDOMEN: Bowel Sounds	<input type="checkbox"/>	<input type="checkbox"/>	
Non Distended	<input type="checkbox"/>	<input type="checkbox"/>	
Nontender/ No Guarding	<input type="checkbox"/>	<input type="checkbox"/>	
No Palp Hepatosplenomegaly	<input type="checkbox"/>	<input type="checkbox"/>	
GENITALIA: Anatomy	<input type="checkbox"/> M	<input type="checkbox"/> F	
Sexual Maturity Rating	<input type="checkbox"/> 1	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
No Acute trauma	<input type="checkbox"/>	<input type="checkbox"/>	

Free of Discharge/Odor	<input type="checkbox"/>	<input type="checkbox"/>
Anus	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL: (Includes Palpation and Joint ROM)		
Scalp	<input type="checkbox"/>	<input type="checkbox"/>
Fontanel(s) (If present)	<input type="checkbox"/>	<input type="checkbox"/>
Ribs	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Reaches with both arms	<input type="checkbox"/>	<input type="checkbox"/>
Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Ankle	<input type="checkbox"/>	<input type="checkbox"/>
Bears weight on both legs	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGIC: Alert		
Muscle Tone	<input type="checkbox"/>	<input type="checkbox"/>
Response to tactile stimuli	<input type="checkbox"/>	<input type="checkbox"/>
SKIN: Includes Palms, Soles and Under Arms (Use Body Diagram on next page for any marks and injuries.)		
No Rashes	<input type="checkbox"/>	<input type="checkbox"/>
No Lacerations	<input type="checkbox"/>	<input type="checkbox"/>
No Bruises	<input type="checkbox"/>	<input type="checkbox"/>
No Bites	<input type="checkbox"/>	<input type="checkbox"/>
No Burns	<input type="checkbox"/>	<input type="checkbox"/>
No Scars	<input type="checkbox"/>	<input type="checkbox"/>



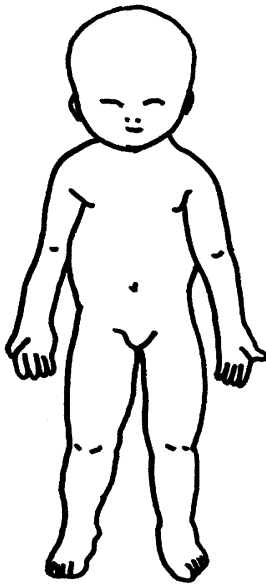
Children's Hospital
and Health System™

Out-of-home Care
Safety Evaluation

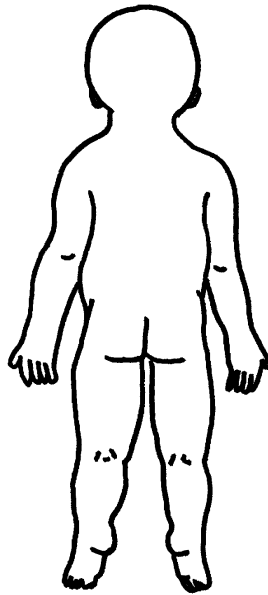
PT NAME :
RN :
DOB :
DOS :

Patient Label

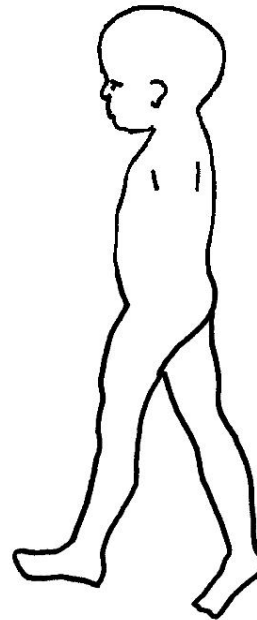
Body Diagram to be completed for marks and injuries on patient's body:



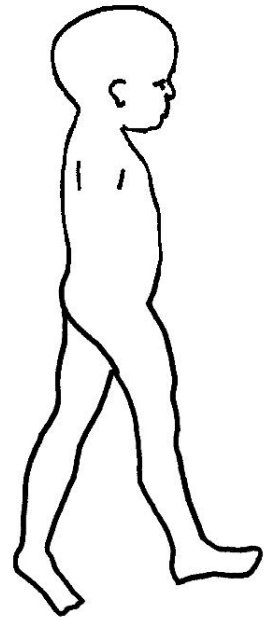
Front



Back

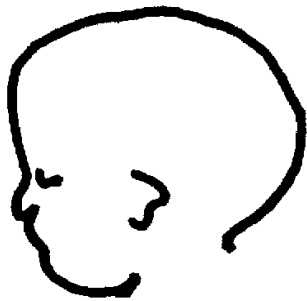


Facing Left



Facing Right

DRAFT:
NOT FOR ACTUAL USE



Facing Left



Front



Facing Right

Photographs taken: Yes No



Children's Hospital
and Health System™

Out-of-home Care
Safety Evaluation

PT NAME :

RN :

DOB :

DOS :

Patient Label

- CBC PT PTT TT vonWillebrand Screen Fibrinogen PFS
- AST ALT Amylase Lipase CPK U/A

Radiology: NONE Skeletal Survey Head CT Other:

ASSESSMENT:

- NO PROBLEMS IDENTIFIED
- PROBLEMS IDENTIFIED/CONCERNS NOTED:

DRAFT:
NOT FOR ACTUAL USE

1. _____
2. _____
3. _____
4. _____

PLAN and RECOMMENDATIONS:

- Consulted with Child Advocacy Physician on-call to discuss concerns. Call 414-266-2000 to page.
- Child Advocacy recommendations were: _____

No Indicators of Abuse Detected.

- Needs Immunization Record verified and may need additional immunizations.
- Recommend Consult: Dental Other consult: _____
- Recommend continuing medication(s):
 - a. _____
 - b. _____
 - c. _____
- Recommend new medications (Rx given if new medications are prescribed):
 - a. _____
 - b. _____
 - c. _____
- Home Medications List updated and sent with patient.
- Other recommendations:

Indicators of Abuse Detected.

- Discussed with Ongoing Case Manager.
- Bureau of Milwaukee Child Welfare notified at (414) 220-SAFE.
- Law Enforcement contacted per BMCW recommendation..
- PMD notified, if information is available.
- ADMIT to Children's Hospital
- Other recommendations:

Completed Evaluations:

(Keep all fax confirmation reports with original medical record.)

- Original forms are sent to Patient Information Department (CHW Medical Records).
 - At PMD Office, keep original in patient's medical record.
- Fax to Child Protection Center at 414-266-8969.
- Fax to Department of Children and Families (DCF) Attention Connie Klick, 608-266-0260.
- GROWTH CHART completed and faxed to CPC and DCF as listed above.

E/M CODE: <input checked="" type="checkbox"/> 99244	ICD-9 Code(s): <input checked="" type="checkbox"/> V61.29 <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Attending Signature: _____ Date/Time: _____	
<small>PRINT NAME</small>	
Child is being released to: <input type="checkbox"/> OCM <input type="checkbox"/> BMCW <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____	
Signature: _____	Date/Time: _____
<small>CASE MANAGER</small>	<small>PRINT NAME</small>
Signature: _____	Date/Time: _____
<small>FOSTER PARENT, IF PRESENT</small>	<small>PRINT NAME</small>

C7734E (12/08)

CREATED BY JANE A CHEVAKO, MD

Milwaukee Case Practice Review Profile (2-2-09)

Reviewer Name:

Review Date:

Section 1: General Information

Case ID #	Case Name:
Child ID#:	Child Name:
Placement Type: COKC Licensed FC TFH Unlicensed relative	Provider Name:
	Provider ID#:
Region: Region 1 (CFCP) Region 2 (CFCP) Region 3 (La Causa) Adoption (CSSW)	Case Manager:
	Supervisor:

Section 2: Child Demographic Information

Child DOB:	Child Gender:
Child race: (select all that apply) African American Asian Hawaiian/ Pacific Islander Native American White Unknown	Results from most recent IA that led to placement: Neglect Medical Neglect Physical Abuse Sexual Abuse Emotional Abuse Abuse Likely to Occur Other:
	Approval date of most recent IA that led to placement:
Child Ethnicity: Hispanic Non-Hispanic	Date placed with this provider:

Section 3: Medical

Prior to out-of-home-care

Detail

Pre-existing medical/behavioral/mental health condition	
Special medical equipment	
Medications	

Hospitalizations/ emergency room visits	

Out-of-home care

Medical Consult Needed 1. Medically fragile 2. Medical evaluation 3. Medical neglect or physical abuse 4. Reviewer judgment	CPC Safety Evaluation Findings: (select one) 1. Medical conditions require immediate follow-up 2. Medical conditions require routine follow-up 3. Medical needs being met
5 day CPC Health Screen conducted	Initial Comprehensive Health Evaluation
Date of 5 day screen:	Date of 30 day exam:
Periodic Well- Child checks conducted:	Appropriate follow-up on health care recommendations
Immunizations up to date	Dental exam completed within 6 months of placement
Current PMD identified	Date of last medical exam (prior to safety medical evaluation):
# hospitalizations while in current placement:	# emergency room visits while in current placement:
Activity on the EDS Report	Special Medical Equipment:
Medications:	

Comments:

Section 4: Child Conditions

Disability/ Special Needs

Learning Disability	Emotionally Disturbed	Other Diagnosed Condition
Mental Retardation/ Cognitive Delay	Anxiety	Asthma
		Cerebral Palsy
Physically Disabled	ADD	Birth Defect
Visually/ Hearing Impaired	ADHD	Diabetes
Developmental Delay	Autism Spectrum	Seizure Disorder
Prematurity	Behavioral Disorder	Substance Exposed
Technology Dependent	RAD	Failure to thrive
Weight Concern	SED	Trauma Exposed

Other:

Comments:

Section 5: Case Practice Process

Birth – 3 Referral Completed	Birth – 3 Assessment Completed
Developmental Delay Identified	Birth -3 Follow-up services provided
Monthly face-to-face contacts with child?	More than 60 days between any face-to-face visits?
Is there an Out-of-home Safety Plan in the file?	Is there a support plan for the foster parents in the file?
Do the needs of the child match the licensing workers recommendation for type of potential placement from pg 2?	
Do the case manager and current licensing worker have a shared understanding of the child’s needs?	Do the case manager and current licensing worker have a shared understanding of the caregiver’s capacities?

Comments:

Section 6:

Status Indicators	Improve	Refine	Maintain	NA
--------------------------	----------------	---------------	-----------------	-----------

Child Status

1. Physical Health	1 2	3 4	5 6	NA
2A.* Emotional Development	1 2	3 4	5 6	NA
2B.* Behavioral Functioning	1 2	3 4	5 6	NA
3.* Behavioral Risk (self)	1 2	3 4	5 6	NA
(others)	1 2	3 4	5 6	NA
4A/4B. Early Learning & Development	1 2	3 4	5 6	NA

Caregiver Status

1. Caregiving Capacities (A)	1 2	3 4	5 6	NA
(B)	1 2	3 4	5 6	NA
2. Special Caregiving Challenges				
(A)	1 2	3 4	5 6	NA
(B)	1 2	3 4	5 6	NA
3. Basic Necessities	1 2	3 4	5 6	NA

Practice review

1 Family Selection	1 2	3 4	5 6	NA
2. Resource & Support Use (child)	1 2	3 4	5 6	NA
(caregiver)	1 2	3 4	5 6	NA
3. Tracking & Adjustment				
(tracking)	1 2	3 4	5 6	NA
(adjusting)	1 2	3 4	5 6	NA

* Indicators are for children 3 and older

Section 7: Strengths and Needs

Strengths found in status indicators (5 or 6) or other areas:

220-SAFE Called based on Case Practice Review Yes or No

Comments:

Immediate follow-up required (1 or 2 on status indicators or other issue)

Comments:

Routine follow-up required (3 on status indicator or other issue)

Comments:

Concerns about non-focus children in the home?

Comments:

Section 8: Summary Comments and Recommendations:

Debrief with case manager occurred Yes or No

Date:

Profile Reviewed by: Name:

Date:

Milwaukee Case Practice Review Profile Qualitative Information

Qualitative indicators related to child and caregiver status and case practice (see below) were used in conjunction with quantitative data to evaluate safety in kinship and foster care homes. Reviewers used the status indicators, in particular, to understand:

- the child's needs,
- the continued ability of the providers to meet the child's needs (caregiving capacity),
- the caregiver's motivation for and understanding of the need for placement,
- the child's adjustment to the placement and their physical and emotional well-being, and
- the family selection and match and the impact on child safety.

While reviewers were able to confirm the safety of the placement by using the review protocol and status indicators as a framework to understand strengths and needs, 103 cases had at least one status indicator was rated 3 or below. This means that more evaluation is required in order to understand the child's needs and the ability of the caregivers to meet those needs necessitating follow-up by case managers.

Child Status

a. Physical Health

This indicator focuses on the child achieving and maintaining optimum health. If the child has a serious or chronic physical illness, the focus is on whether the child is achieving his/her best attainable health status given the disease and prognosis.

This indicator examines if a child's basic needs (proper nutrition, clothing, shelter, and hygiene) are met on a daily basis. This includes medical and dental care (preventive, acute, and chronic). Preventive health care is also a part of this indicator and includes periodic examinations, immunizations, dental hygiene, and screening for possible developmental or physical problems.

b. Emotional Development (Age 3 and Older)

This indicator is concerned with emotional development, life adjustments, appropriate coping skills, and self-management essential to adequate daily functioning in a child's life. This includes having a sense of person, purpose, personal worth, and emotional connections.

c. Behavioral Functioning (Age 3 and Older)

[This indicator takes into account any trauma and psychiatric history, as well as other co-occurring conditions that may be present.]

Behavioral functioning addresses the manner in which the child interacts with others and his/her environment on a current daily basis. This includes 1) avoiding destructive behaviors in the home, school, or community, 2) demonstrating good judgment regarding age appropriate activities, using

time in a constructive manner, 3) handling life events in a way that fulfills roles and expectations, and 4) articulating his/her needs and taking meaningful steps to address those issues.

For children diagnosed with an emotional disturbance, the focus is on whether the child is learning how to self-manage his/her behaviors and is using the necessary skills to function well in the school, home, and community on a daily basis.

d. Behavioral Risk (Age 3 and Older)

This indicator is concerned with lawful community behavior, engagement in socially appropriate activities, and avoidance of risky activities. Thus, self-endangerment and posing risk of harm to others are central concerns of this indicator.

The focus of this indicator is the choices and decisions and subsequent behaviors and activities that children make as it relates to engaging in risky or potentially harmful activities. For younger children, some examples of potentially harmful activities could include: excessive lying or running away, leaving home/supervision for extended periods of time, aggressive biting or pulling hair, extreme tantrums, fighting to the extent of causing bodily harm, playing with fire, cruelty to animals.

e. Early Learning and Development (Under Age Five)

This indicator focuses on:

- Social/emotional development
- Cognitive development
- Physical/motor development
- Language development
- Self-care skills
- School readiness (e.g., basic knowledge and learning skills, self-care and social skills, attention focus, ability to follow instructions, positive attitudes toward learning and group participation)

f. Learning and Development (Over age Five)

This indicator focuses on the developmental, educational, and/or vocational processes that enable the child to build skills and functional capabilities at a rate and level consistent with his/her age and abilities.

2. Caregiver Status

a. Caregiving Capacities

This indicator focuses on whether the caregiver demonstrates adequate caregiving capacities on a reliable daily basis in order to provide the child(ren) with appropriate nurturance, guidance, protection, care, and supervision. If the child(ren) have special medical, emotional, behavioral, and/or developmental needs, this includes the caregiver's knowledge, skills, and supports that may be required to meet the needs of the child(ren).

b. Special Caregiving Challenges

The focus of this indicator is assessing the degree to which caregivers, with whom the child is currently residing, present or experience a pattern of significant, ongoing challenges that limit or adversely affect their capacity to function successfully as an adequate caregiver for this child.

This may include one or a combination of the following challenges:

- Limited cognitive abilities (mental retardation, traumatic brain injury)
- Serious mental illness (depression, bi-polar disorder, schizophrenia)
- Substance abuse impairment or addiction
- Domestic violence (repeated pattern, serious risk/injury)
- Unlawful behavior pattern and incarceration
- Serious illness or disabling physical condition
- Adverse effects of poverty (e.g., inadequate income; inadequate housing/homelessness; lack of child care, health care, transportation, etc.)
- Cultural or language barriers adversely affecting caregiving abilities or doing child rearing inconsistent with normative expectations in the US
- Non-US citizen without required documentation and unable to meet basic needs of the child or family
- Extraordinary demands placed on the caregiver (e.g., multiple children under age five; high child/caregiver ratio; frail elderly, mentally ill persons in the home; single caregiver attempting to meet an extraordinary care burden within the home)
- Immaturity of a caregiver lacking skills and judgment for child care
- Life disruption and dislocation caused by natural disasters leading to homelessness and/or inability to meet child and family needs

c. Basic Necessities

This indicator considers:

- The adequacy of the caregiver family's earned income and/or economic supports to cover the family's basic living requirements (i.e., shelter, food, clothing, transportation, health care/medicine, child care)?
- Whether the caregiver is accessing, receiving, and adequately managing the economic supports to which he/she is entitled.
- Whether the caregiver has economic security and skills sufficient to meet the family's basic needs and maintain a stable living arrangement for the children.

3. Practice

a. Family Matching

This indicator focuses on the quality of the current child/family match. This is judged on: (1) the consistency of the “fit” between the requirements of the child and the capacities of the family to meet these requirements; (2) placement of the child with siblings in the same family, when applicable; (3) the ability of the family to work with challenging behaviors and to build necessary skills to meet special needs, and (4) the stability and quality of ongoing interactions between the

child and the caregiver family.

b. Resource and Support Use

The focus of this review indicator is on active efforts by service providers (e.g., caseworker, parent aide, parent education, trainer, nurse, respite provider) to prepare and assist the out-of-home caregiver to acquire, adapt, and maintain the skills, guidance, resources, formal and informal supports, and relief necessary to meet both regular and any extraordinary needs presented by the child (or sibling group) while maintaining the stability of the home and commitment to the child.

The degree of training and support provided is directly related to the probability that: (1) a stable placement will be achieved near-term and (2) a permanent living arrangement could be provided long-term, via family reunification or adoption. Such supports are necessary whether the out-of-home caregiver is providing temporary care or developing their long-term capabilities to care for the child in the event that adoption or guardianship becomes a path to permanency.

c. Tracking and Adjustment

This indicator looks at the ongoing process used by the family team to track service implementation, check progress, identify emergent needs and problems, and modify services in a timely manner.

Milwaukee Provider Home Background Checks and Study Review (Draft 1-30-09)

Reviewer Name: _____ Review

Date: _____

Type of Provider: Licensed Foster Home (56) ___ Treatment Foster Home (38) ___ Court Ordered Kinship ___

Licensed Providers: Non-relative ___ Relative ___

Provider #1 ID:

Provider #1 Name:

Provider #2 ID:

Provider #2 Name:

Completed HFS 56 Checklist in file Y / N

Comment:

Background Checks

(Note: Include all adult household members and all children 12 years of age and older.)

Household Member Denote FP/Caregiver With a (C)	Age	Race/Ethnicity <i>(see Section 2)</i>	CPS-CAN <i>Includes any state lived in the last 5 year if licensed after 1/1/08</i>	DOJ <i>Name based Fingerprint-based if licensed after 1/1/08</i>	Caregiver <i>IBIS Letter</i>	DOTI	MPD/DV	Other Local PD/DV-Criminal Background	Out of State/ County	CCAP	JV	BID

Comments:

Licensing

Effective Date:
Exceptions:
Licensing Agency
Licensing Worker

Expiration Date:

Study Review Areas:

History:

RFA Overall Evaluation Section Score: Provider 1: _____ Provider 2: _____
Reviewer Score (QSR): Provider 1: _____ Provider 2: _____
Comments:

General Parenting:

RFA Overall Evaluation Section: Provider 1: _____ Provider 2: _____
Reviewer Score (QSR): Provider 1: _____ Provider 2: _____
Comments:

Specialized Parenting:

RFA Overall Evaluation Section Score: Provider 1: _____ Provider 2: _____
Reviewer Score: Provider 1: _____ Provider 2: _____
Comments:

The licensing worker's recommendations for types of potential placements.
(Number of, gender, age range, level of care of child/children)

Follow up questions for child case reviewer:

Summary:

Kinship Care Providers (Note: Include all adult household members and all children 10 years of age and older.)

Household Member Denote Caregiver With a (C)	Age	Law Enforcement Records Check	DOJ	CCAP	Criminal Background	CPS Records Check	Home Visit <i>At placement or within 24 hours</i>

Date of Approval:	Worker who approved the home:
Date of most recent Kinship Living Review: (Must be within 12 months)	Kinship agreement in file: Y / N (if yes provide date):

Comments:

Additional Case Practice Review Data

Child Gender	#	%
Female	244	48.5%
Male	241	47.9%
Not Identified by Reviewer	18	3.6%
Total	503	100.0%

Child Race	#	%
African American	288	57.3%
Asian	2	0.4%
Multi-Racial	38	7.6%
Native American	17	3.4%
Unknown	29	5.8%
White	129	25.6%
Total	503	100.0%

Child Ethnicity	#	%
Hispanic	78	15.5%
Non-Hispanic	362	72.0%
Unknown	63	12.5%
Total	503	100.0%

Placement Type	La Causa %	CFCP %
COKC	35.1%	29.9%
Licensed FC	40.5%	43.6%
TFC	15.5%	18.8%
Unlicensed Relative	8.9%	7.8%