Systems Change Review Orientation – Part 2

Milwaukee Partnership Council

Critical Incident Subcommittee

1/19/21

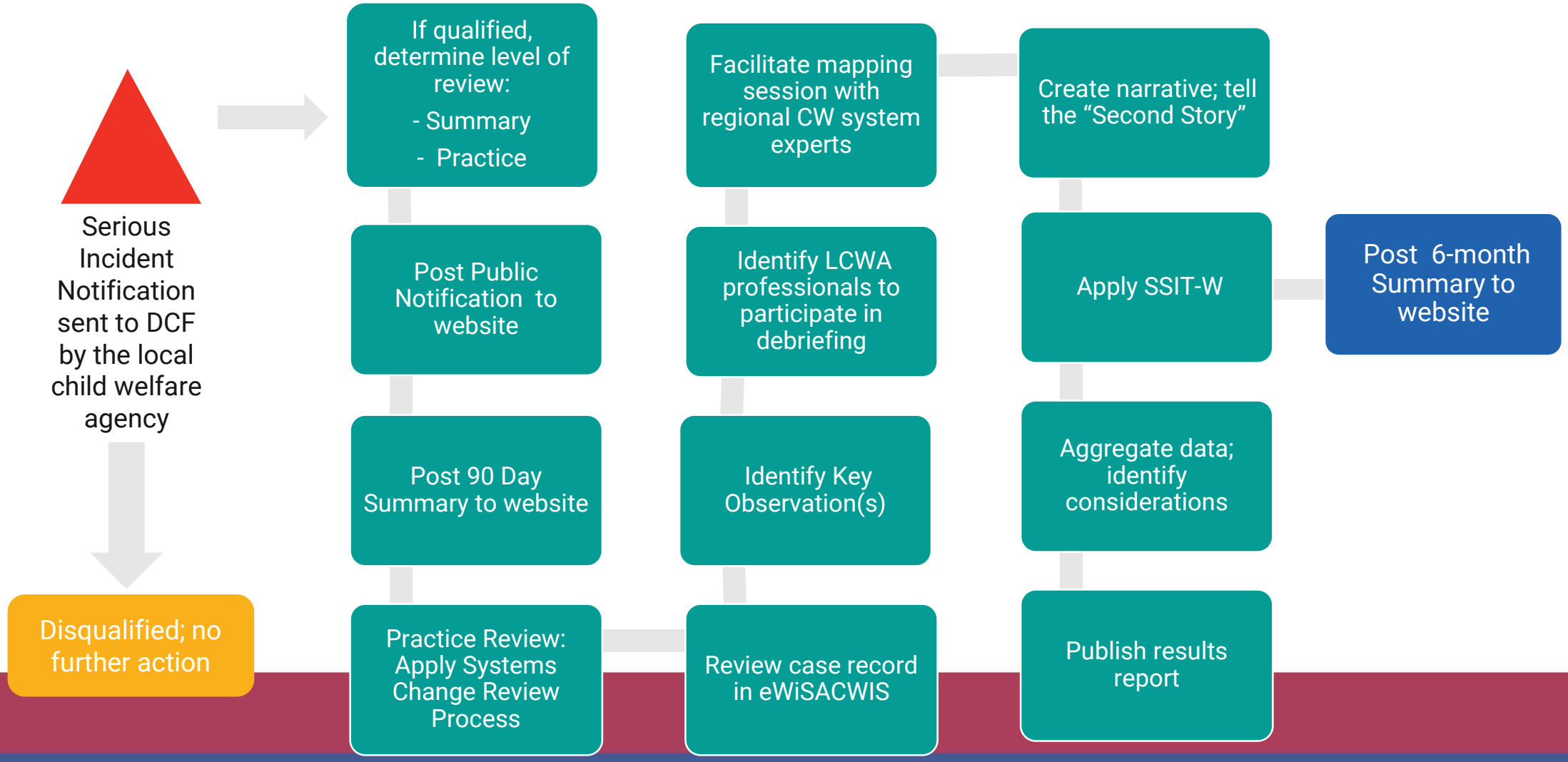
Agenda

- Brief recap (10 minutes)
- Scoring (10 minutes)
- Data (30 minutes)
- Questions (10 minutes)

Wisconsin Critical Incident Review Process

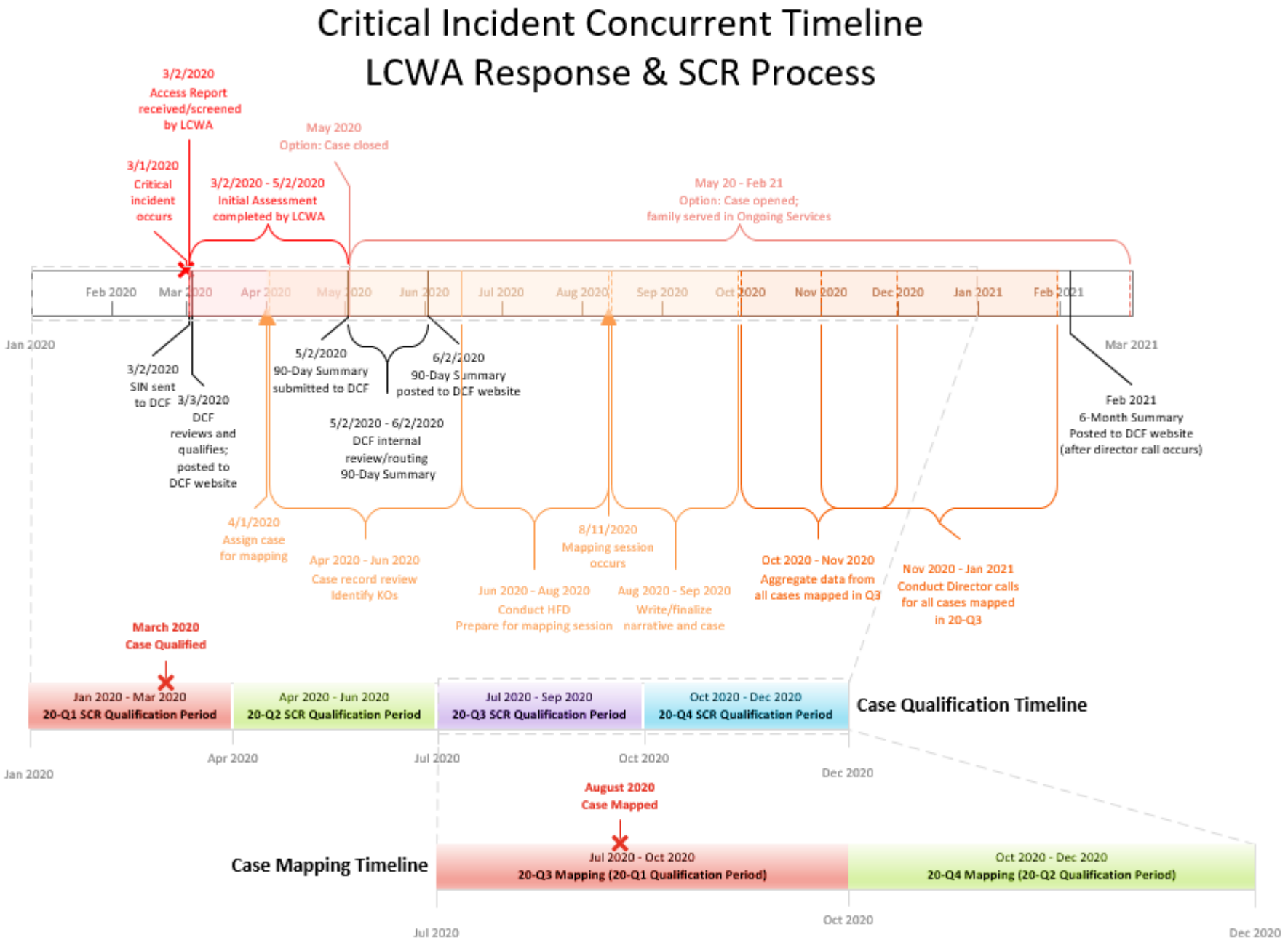
Brief Overview

Systems Change Review Process Flow



SCR Process

- BOS implemented in November 2016; Milwaukee implemented in June 2018
- Cases qualify based on frequency or recency of relevant contact with CPS
  - Cases do not qualify for a SCR based on the level of egregiousness or seriousness of the critical incident
- DCF notifies agency directors when a case qualifies for a SCR
- Qualified cases are mapped two quarters later



- Critical incident review process is different and separate from local child welfare agency response
- Two processes happening concurrently

Case Record Review

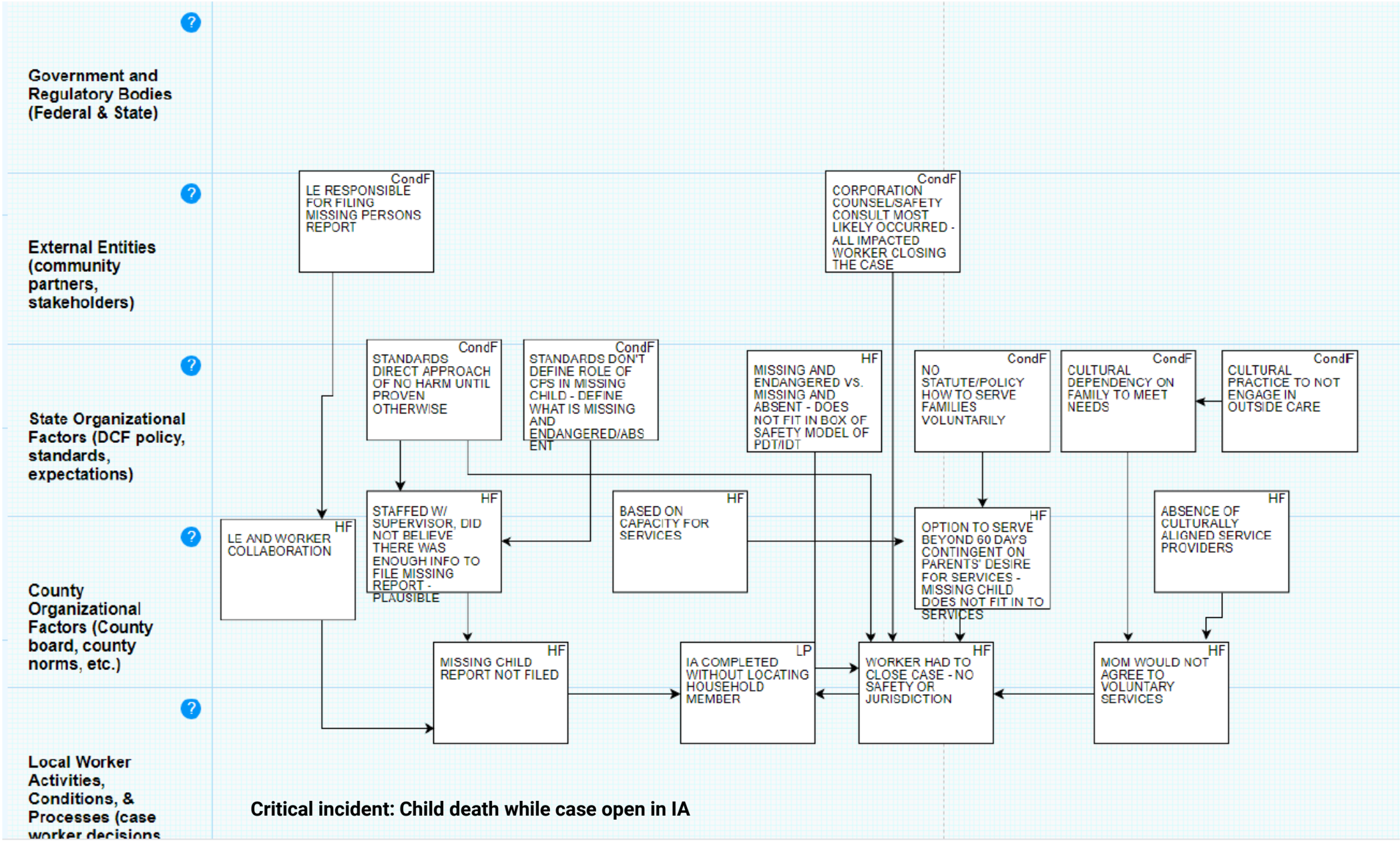
- Case record review completed by Wisconsin Reviewer
  - PUR: 1 year prior to the critical incident
  - Not reviewing critical incident
  - Includes all relevant case work from any county/agency (Access, IA, Ongoing, Licensing, etc…)
  - Concludes with identification of Key Observations
- Key Observations are case facts that provide opportunities for studying and further learning

Human Factors Debriefing (HFD)

- One-on-one session with professionals aimed at gathering additional information that cannot be found in the case record
  - CPS professionals identified to participate based on the Key Observation(s)
  - Conducted individually with by Wisconsin Reviewer
- Goal: Learn how decisions are made in context:
  - How CPS professionals are focusing and directing their attention
  - How CPS professionals gain, activate and apply knowledge that guide decisions and actions
  - What CPS professionals are trying to pursue or accomplish when making decisions or taking actions

Systems Mapping

- Facilitated by the Wisconsin Reviewer
- Explores identified Key Observations and their influences at different levels of the system
- Regional Mapping Teams and standing Mapping Participants:
- Ad hoc members from the local child welfare agency may be identified to join depending on case factors



Critical incident: Child death while case open in IA

Narrative – Second Story

- Written by the Wisconsin Reviewer
- Derived from information learned in the Human Factor Factors Debriefing and Systems Mapping process
- Purpose of the narrative is to tell the second story by providing contextual information to understand decision-making related to the Key Observation(s) studied

KO: IA completed and case closed without locating one of the children.

There were several factors that impacted the case being closed without verifying the location of the child. The safety analysis tool from the Safety Model does not account for absent or "missing" children. As a result, the information gathered during the 60-day assessment did not meet the safety threshold criteria indicating a present or impending danger threat. Further the Access and IA Standards do not automatically identify absent/missing children as a type of maltreatment. A second factor was the lack of information to support that abuse or neglect had occurred or was likely to occur, indicating there was no jurisdiction under Chapter 48 to continue to formally intervene in the family. While there were several staffings on this case during the 60-day assessment period that included a safety consult and involved the Corporation Counsel, Corporation Counsel did not believe the inability to locate the child was sufficient evidence to support taking legal action in this case.

Additionally, without an identified safety concern or maltreatment allegation CPS does not have jurisdiction and voluntary case management is the only other option to continue to work with families beyond 60 days. The decision to provide voluntary services varies from county to county depending on capacity to manage this category of cases in addition to court ordered cases, as well as the availability of necessary services in the community. Further, the Access and IA Standards do not provide any guidance in the provision of voluntary services or in what situations voluntary involvement beyond the 60 days would be encouraged. While there is the ability in this county to serve families beyond the 60-day assessment period, the family has to be willing to engage in voluntary services and have identified service needs. The inability to confirm the child's whereabouts is not considered a service need that would necessitate ongoing involvement by the county.

Scoring

- Safe Systems Improvement Tool – Wisconsin (SSIT-W)
- Scores reflect whether an item was present and relevant in a case and supported by evidence
- Exemplars are used to explain scores of 2 or 3 to maintain integrity and provide detail of how the category manifested in a particular case
- Ratings translate to action levels designed to support quality improvement

Scoring

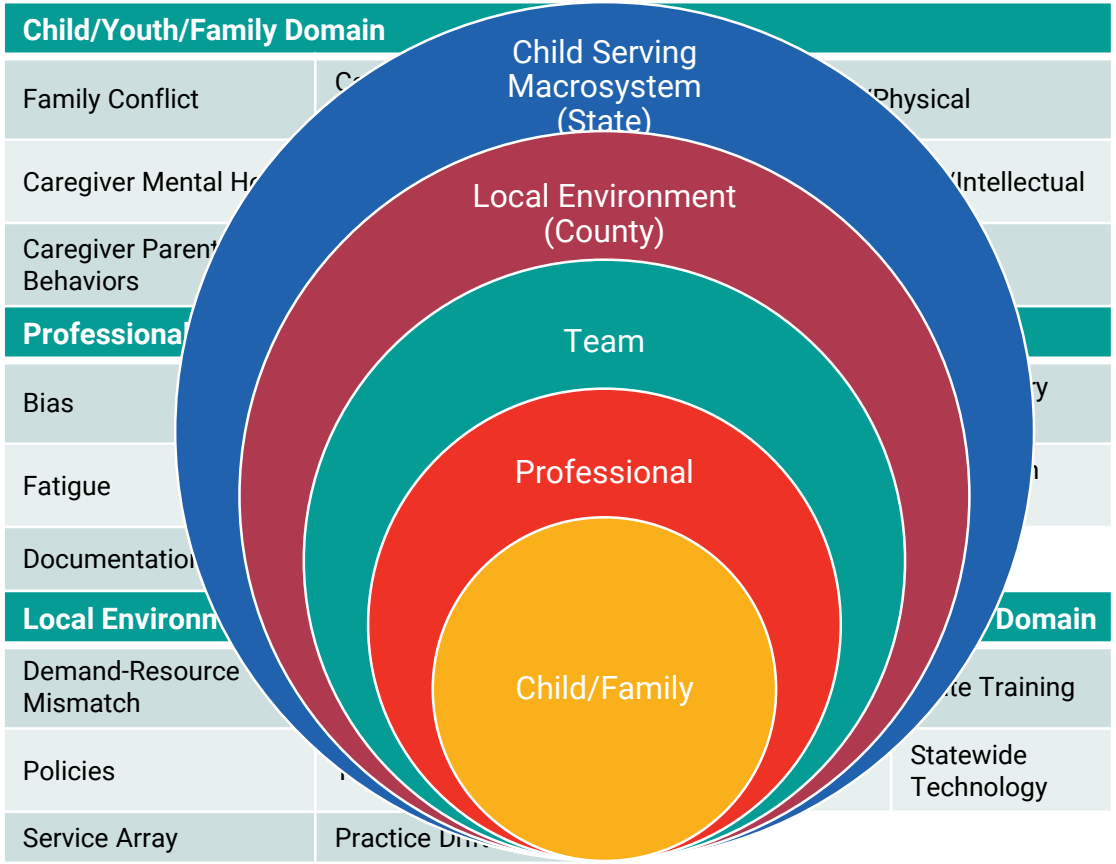
SSIT-W

Safe Systems Improvement Tool – Wisconsin Version (SSIT-W)

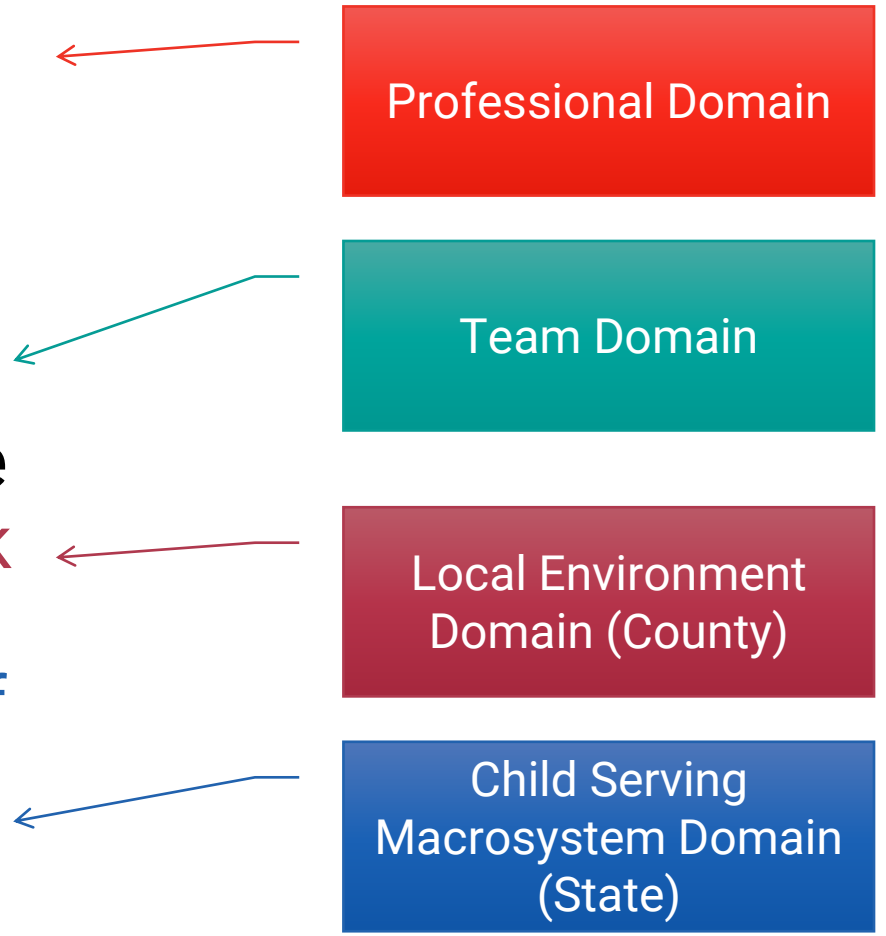
- SSIT-W created in collaboration with the National Partnership for Child Safety (NPCS) in 2020
  - First developed in TN Department of Children's Services' critical incident reviews
  - Modified to best facilitate learning and communication in Wisconsin's state-supervised, county-administered child welfare system
- Provides structure to the output of the critical incident review process
  - Organizes learning
  - Shares the "system's story" of a critical incident
  - Measures pressure existing within organizations
  - Identifies opportunities for targeted system reform and quality improvement work
- Only completed once (for each KO narrative), at the end of every case review
- Scores aggregated and analyzed quarterly and annually to review findings and discuss trends

SSIT-W Structure

- Organized into 30 items across 5 domains
- Domains are nested
  - Each item within a domain is unique and not replicated in other items
  - Guide reviewers into assessing and understanding all system levels and influences
  - Domains are not mutually exclusive



A professional may have experienced trouble interpreting external assessments (e.g., medical records) about a child with complex needs, and which may have been exacerbated by the availability and case direction given by the supervisor. These factors may be further affected by the presence (or lack thereof) of helpful local policy and internal professionals and by the lack of state policy and training to support the interpretation of medical records.



SSIT-W Scoring

- Items scored on 0-3 scale
  - 0 = no evidence
  - 1 = latent factor
  - 2 = influence to KO without proximity to outcome
  - 3 = influence to KO with proximity to outcome
- Scores of 2 or 3 means item affected the KO
  - Includes narrative description to support rating

- 3s are not “worse” than 2s
- 3s do not mean there is more influence/impact of the item in the case than 2s
- Scores of 2s and 3s mean something different
  - Organize system for a targeted response

SSIT-W Scoring

- Proximity used to differentiate between ratings of 2 and 3
  - Gestalt principle about how the human mind naturally organizes items
  - Proximal if KO was close in **time**, **distance** or **relationship** to the critical incident and *can reasonably be related to the incident*
  - Proximity ≠ Causality
- Promotes rating reliability
  - Fairly easy to agree on proximity
- Secures understanding of system-level needs most proximal to the critical incident

- Items scored the same across all system domains
  - Each influencing item is ascribed equal importance
  - Promotes learning deep into the system to identity opportunity for quality improvement
  - Prevents overweighting professional and team items

SSIT-W Scoring

Item scores also organize to quality improvement actions

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to KO without proximity to the outcome	QI action may be needed to promote best practices in casework. KOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to KO with proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include comparing with other quality data in order to consider options for system-level improvement projects.

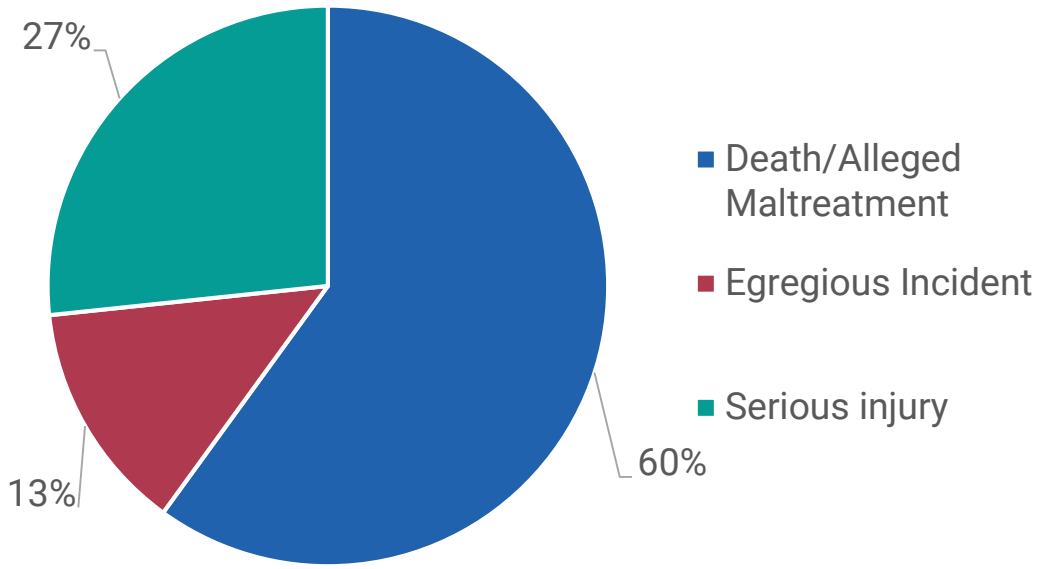
2019-2020 DMCPS SCR Data

2019-2020 SCR Data

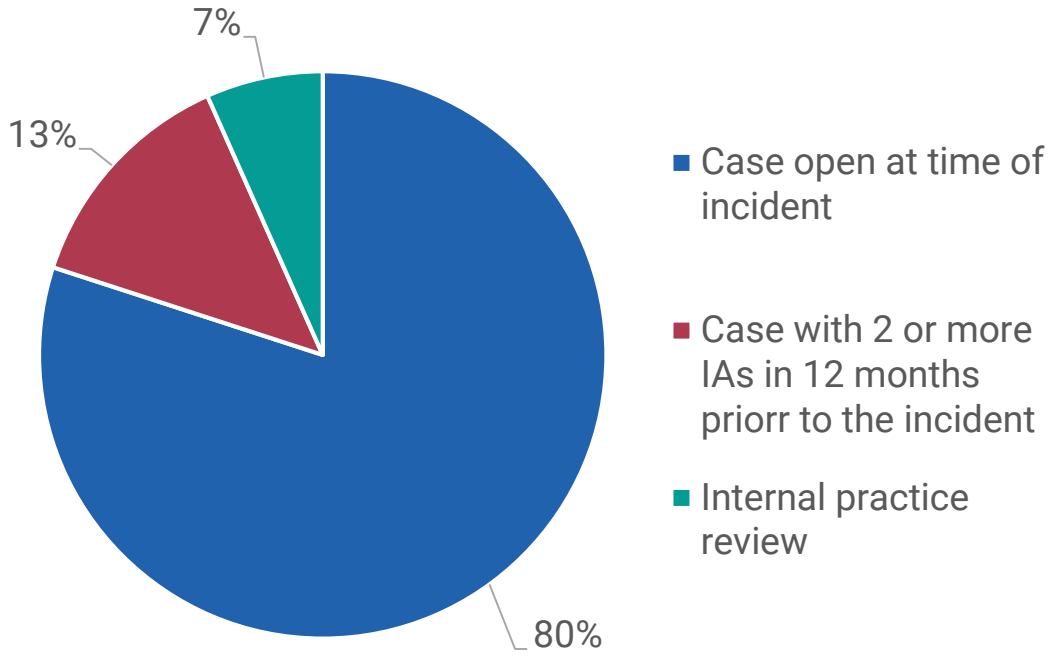
- 17 critical incidents noticed by DMCPS to DSP
  - 2 cases work reviewed from another LCWA; cases excluded from DMCPS data
- 15 cases where critical incident occurred in Milwaukee and work reviewed included DMCPS and/or one of the contract agencies

SCR Case Qualification Data

Cases Qualified for Practice Review by Critical Incident Type



Cases Qualified for Practice Review by Qualification Reason



n = 15 cases

SCR Case Qualification Data*

- **Critical Incident Types**

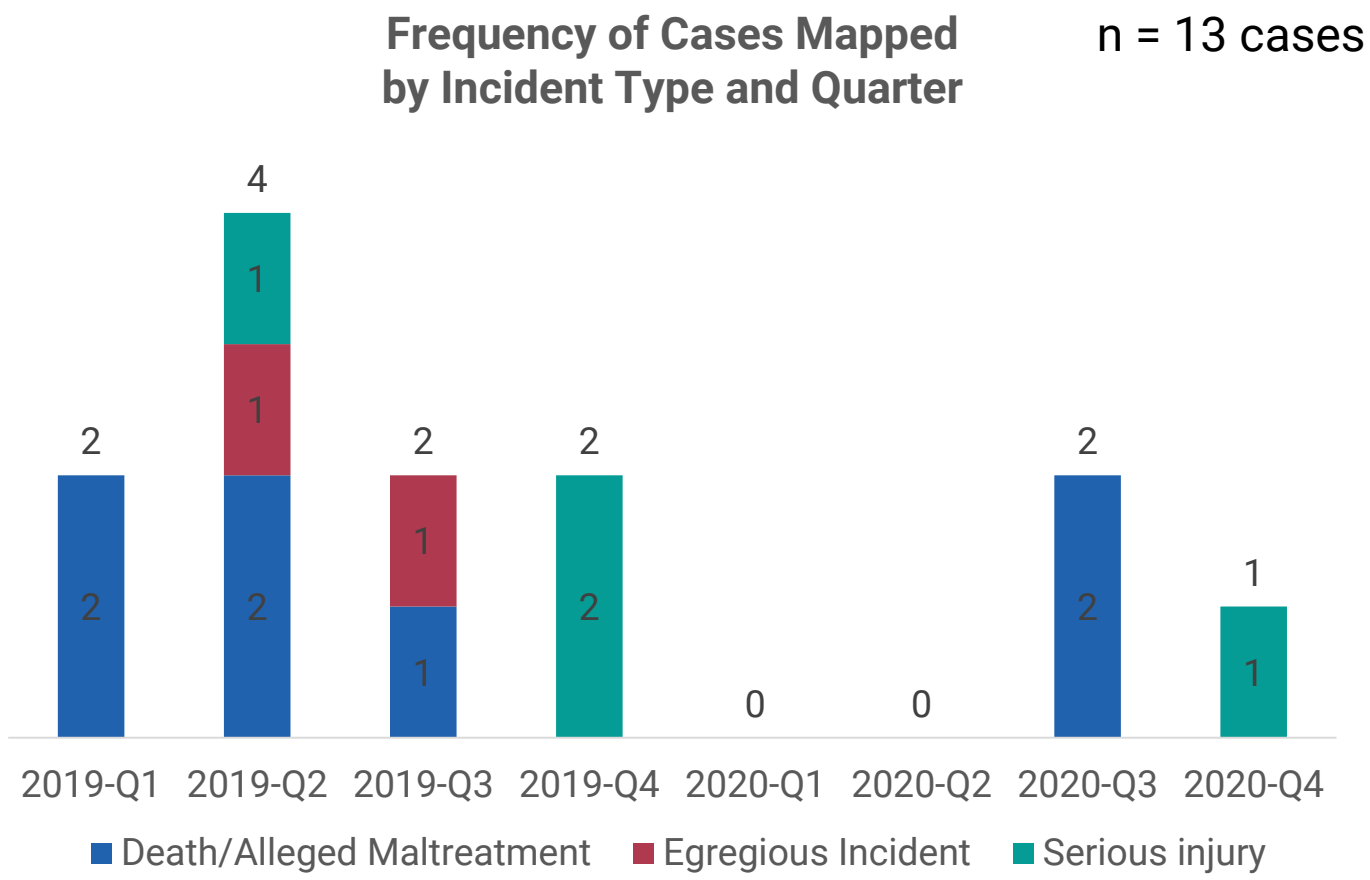
- A child or youth death due to alleged maltreatment
- An egregious incident of abuse or neglect to a child or youth
- A serious injury, as determined by a physician, to a child or youth
- A child or youth suicide while that child or youth is placed outside of the home under a court order

- **Qualification Reasons**
  - The Division of Safety and Permanence (DSP) reviews each critical incident submitted by counties under Act 78 to determine if it qualifies for the SCR process based on one or more of the following criteria:
    - Case open, either to Initial Assessment (IA) or Ongoing, at time of incident
    - Case with 6 or more contacts with Access in 12 months prior to the date of the incident
    - Case with 2 or more contacts with Access in 3 months prior to the date of the incident
    - Case with 2 or more IAs in 12 months prior to the date of the incident
  - Reviews only occur after it has been determined that the critical incident meets the statutory definition/requirement for Act 78 public disclosure

***Slide added as a result of feedback during the presentation on 1/19/2021**

Case Mapping Data

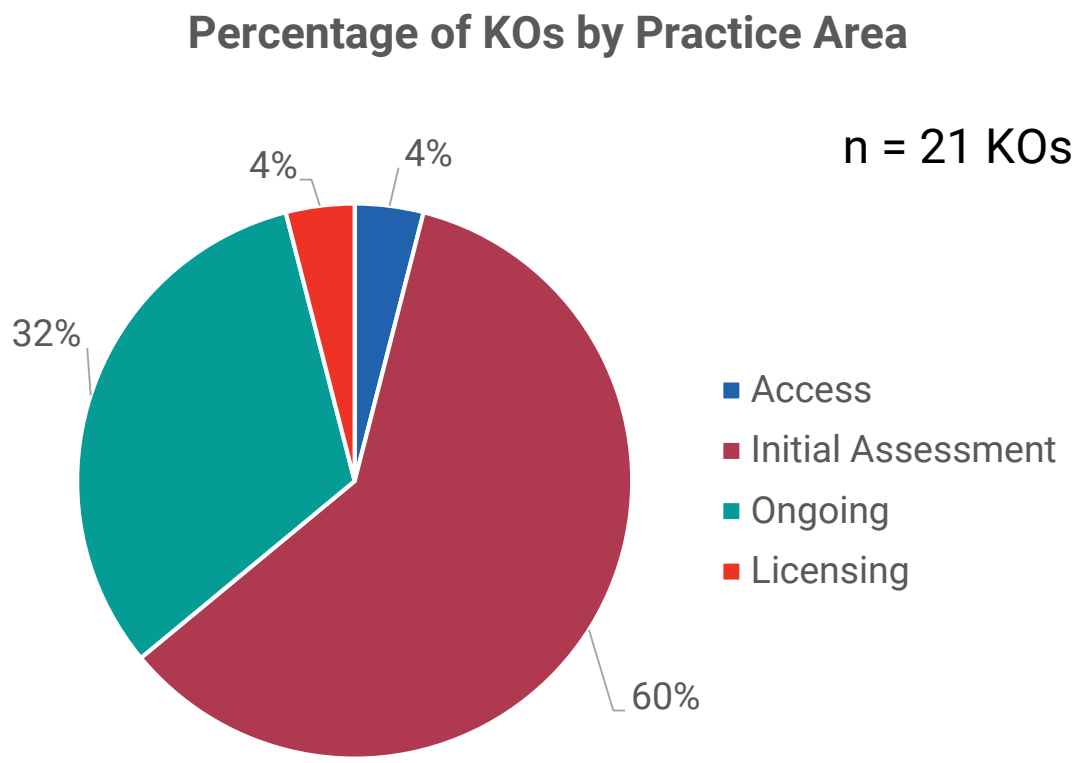
- 13 cases with KOs presented to mapping teams
- 2 cases not mapped
  - No KOs identified
  - KOs reconciled after HFD



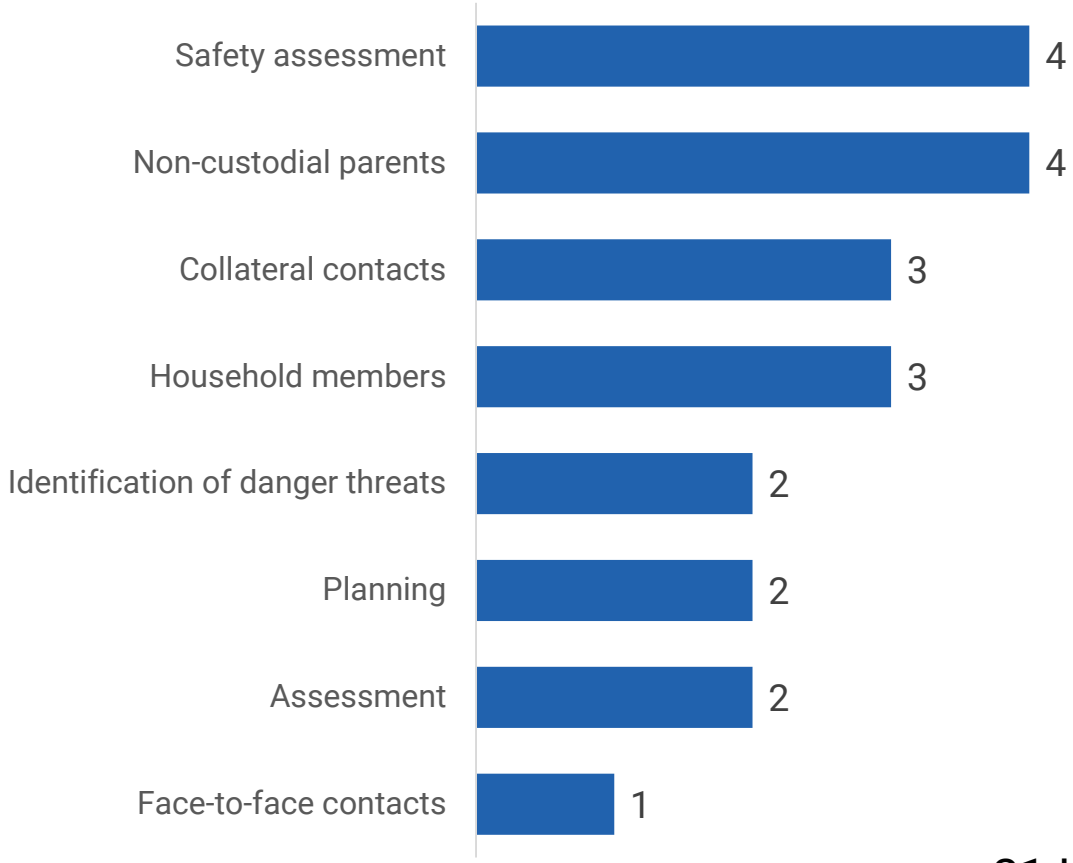
Key Observations

- 13 cases; 21 unique KOs identified
  - (1) deviations from policy or expected practice or
  - (2) decisions or actions within normal case practice

- KOs categorized by:
  - Practice area
  - Primary theme
  - Secondary theme
  - Scoring items



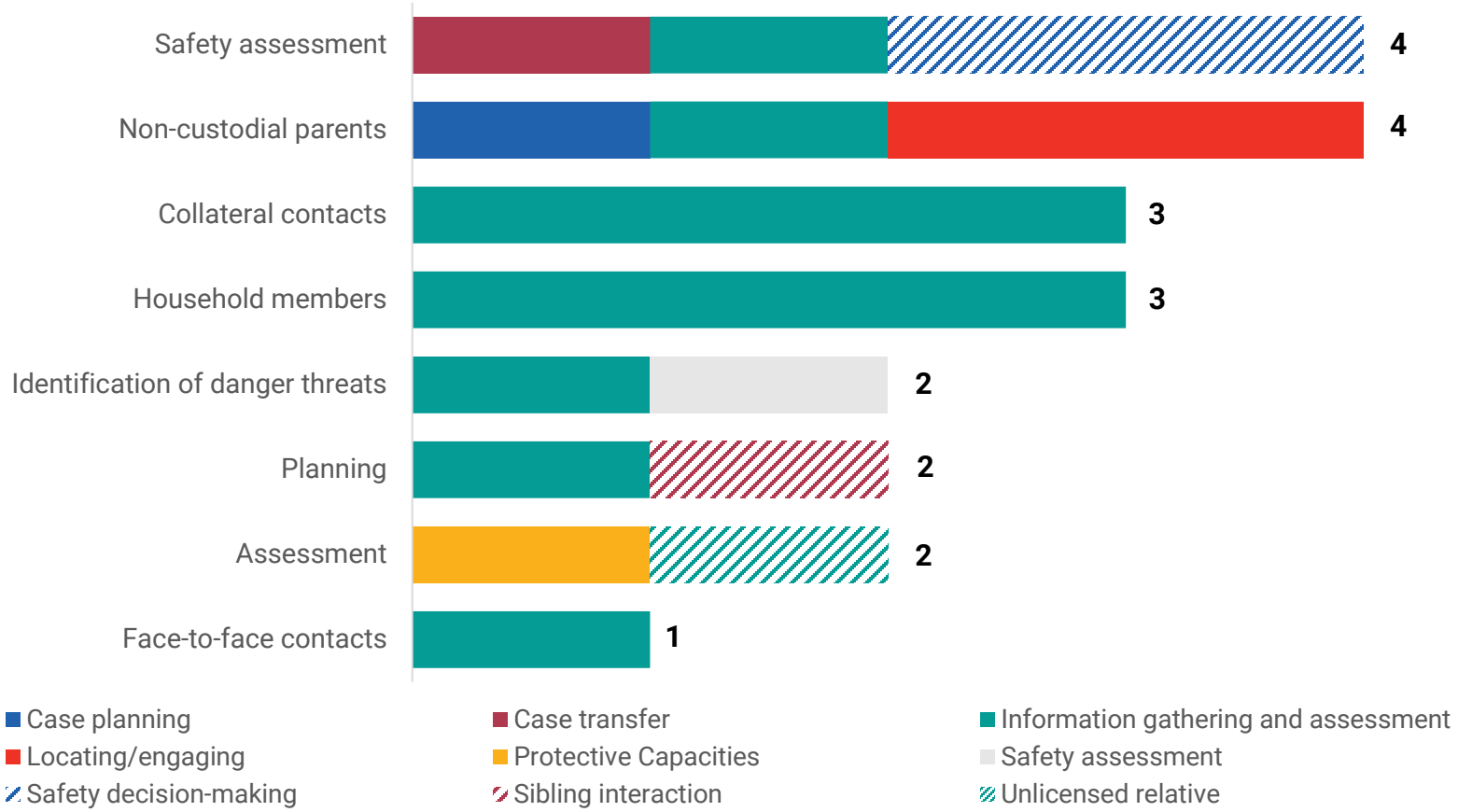
Key Observation Primary Themes



n = 21 KOs

- Safety assessment or reassessment were not completed, completed with incomplete information or not documentation.
- No or minimal efforts were made to locate and/or engage non-custodial parents in information gathering, assessment, or case planning.
- Information from collateral contacts was not gathered during the Initial Assessment in order to inform safety-related or case-related decision-making.
- Household members were not identified and/or information was not gathered from all household members during the Initial Assessment.
- Present and/or impending danger threats were not identified at Access and/or during the Initial Assessment.
- Case planning information not informed by an ongoing assessment process or sibling interaction did not occur.
- Assessment of protective capacities did not occur or assessment of unlicensed relative did not occur.

Key Observation Secondary Themes



- KO second themes provide additional context
- Information gathering and assessment accounted for 50% of KO secondary themes

PRELIMINARY Scoring Data

Frequency of Items Scored 2 or 3

- Data removed as it was preliminary data and is not ready for public distribution

PRELIMINARY Scoring Data

Percentage of Items Scored 2 or 3

- Data removed as it was preliminary data and is not ready for public distribution

Next Steps

- Finalize 2020 data
  - Scoring data for cases mapped in 20-Q4
- Analyze data by KO primary theme
  - Practice Area
  - Secondary Theme
  - Scoring Items
  - Exemplar Summary
- Submit report to DMCPS leadership

Discussion & Questions

Resources*

- Public Disclosure of CPS Critical (Egregious) Incident Reports
  - https://dcf.wisconsin.gov/cps/incidents
- Act 78
  - https://dcf.wisconsin.gov/cwportal/access-ia/act78
  - https://docs.legis.wisconsin.gov/2009/related/acts/78.pdf

***Slide added as a result of feedback during the presentation on 1/19/2021**

Thank You!

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