Allegheny County Department of Human Services Quality Improvement Activities: 2009–2011

PREPARED BY

Jean O'Connell Jenkins, Katie Meehan Arvay, Ebony Robinson, Evelyn Whitehill and Erin Dalton

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The Allegheny County
Department of Human Services
One Smithfield Street
Pittsburgh, Pennsylvania 15222

PHONE 412.350.5701
FAX 412.350.4004
www.alleghenycounty.us/dhs

Contributors

The DHS Office of Data Analysis, Research and Evaluation (DARE) thanks the following people for contributing to this report:

- **Karen Blumen**, Deputy Director, DHS Office of Community Relations
- **Heather Lynn Fisher**, Specialist, Director's Action Line, DHS Office of Community Relations
- **Ruth Ann Koss**, Supervisor of Mental Health and Child Adolescent Services, DHS Office of Behavioral Health
- **Charles Martin**, Casework Practice Manager, DHS Office of Children, Youth and Families
- **Jeanine Rasky**, Director of Integrated Systems
- **Mary Beth Rauktis**, Assistant Professor, School of Social Work, University of Pittsburgh
- **Dan Robinson**, Manager, Director's Action Line, DHS Office of Community Relations
- **David Vereb**, Quality Specialist, DHS Office of Behavioral Health

Allegheny County Department of Human Services

The Allegheny County Department of Human Services (DHS) is dedicated to meeting the human services needs of county residents, particularly the county's most vulnerable populations, through an extensive range of prevention, intervention, crisis management and after-care services.

This report was prepared by the Office of Data Analysis, Research and Evaluation (DARE), an office within DHS. DARE supports and publishes research related to the activities of DHS in a number of categories, including: Aging; Basic Needs; Behavioral Health and Disabilities; Child Development and Education; Children, Youth and Families, Crime and Justice; and Innovation, Reform and Policy.

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ACRONYMS

AFC	Adoption/Foster Care office
CFNF	Child Fatality/Near Fatality
CFSR	Child and Family Services Review
COA	Council on Accreditation
CPSL	Child Protective Service Law
CQI	Continuous Quality Improvement
CYF	Office of Children, Youth and Families
CRO	Central Regional Office (CYF)
DAL	Director's Action Line
DARE	Office of Data Analysis, Research and Evaluation
DHS	Department of Human Services
DPW	Pennsylvania Department of Public Welfare
ERM	Emergency Response Meeting
ERO	East Regional Office (CYF)
FGDM	Family Group Decision Making
FWR	Placement with a Fit and Willing Relative
HFW	High-Fidelity Wraparound
ILI	Independent Living Initiative
ISPP	Integrated Service Planning Process
LIO	Lexington Intake Office (CYF)
MPP	Maximizing Participation Program
(MS)RRT	(Multi-System) Rapid Response Team
MVRO	Mon Valley Regional Office (CYF)
NGA	National Governors Association
NBPB	Needs-Based Plan and Budget

Acronyms
(continued)

NRO	North Regional Office (CYF)
OBH	Office of Behavioral Health
OCR	Office of Community Relations
OCS	Office of Community Services
OID	Office on Intellectual Disabilities
OPLA	Other Permanent Living Arrangement
PIP	Program Improvement Plan
PPS	Pittsburgh Public Schools
PQI	Performance and Quality Improvement [standards]
QI	Quality Improvement
QIA	Quality Improvement Assessment
QSR	Quality Service Review
RTF	Residential Treatment Facility
SE	Special Education
SPLC	Subsidized Permanent Legal Custodianship
SRO	South Regional Office (CYF)
SUID	Sudden Unexplained Infant Death

EXECUTIVE SUMMARY

Since 2008, the Allegheny County Department of Human Services (DHS) has prioritized the development and implementation of an enhanced Quality Improvement (QI) process for the delivery of direct services in Allegheny County. Following an extensive analysis of existing QI activities throughout DHS's program offices, a QI Department was established within the Office of Data Analysis, Research and Evaluation (DARE), with responsibility for independent, impartial reviews of direct services. While the primary focus of its efforts has been the child welfare system, the QI Team has begun to expand its efforts into other DHS offices.

Improvement activities conducted by various QI staff across offices include a variety of legislatively mandated and non-mandated reviews. A three-year review of key QI activities is detailed in this report, including:

Quality Service Review (QSR): Allegheny County DHS's Quality Service Review process is a measure of the child welfare system's practice model and associated standards, which was established to promote a culture of excellence in serving children, youth and families. This report includes a summary of findings as well as a link to an independent report that describes the QSR process, provides findings of the 2011 QSR, and offers recommendations for improvement of case practices and system performance.

National Governors Association (NGA) Qualitative Case Reviews: In 2009, Allegheny County was selected by the National Governors Association Policy Academy to participate in the *Safely Reducing the Number of Children in Foster Care* initiative. Monthly qualitative case reviews with presentations of relevant administrative data associated with permanency outcomes were held across the CYF regional offices from February 2009 through March 2011. During this time, 84 family cases were reviewed; these cases included 177 focus children and 161 siblings.

Executive Summary
(continued)

Forty-six percent of the children reviewed were in foster home placements; 23 were in kinship care. Most of the children had a permanency goal of returning home; adoption was the second most common goal.

Key recommendations identified during these reviews included the following themes: enhance the timeliness of adoption; focus on educational stability; evaluate parental substance abuse and its impact on the safety and well-being of the children, and develop a related safety plan prior to consideration for removal; and improve training for casework and administrative staff on the Family Finding model.

Act 33 Of 2008 Child Fatality / Near-Fatality Case Reviews (CFNF): Legislatively mandated in Act 33 of 2008, Act 33 case reviews are held whenever a child fatality or near-fatality occurs under circumstances where there is suspicion and/or substantiation of child abuse or neglect.

From 2009 through 2011, 34 incidents were reviewed by the Act 33 Team; 13 were child fatalities, and 21 were near-fatalities. While the number of near-fatalities remained consistent at seven each year, fatalities increased from two in 2009 to three in 2010 and eight in 2011. Thirty of the 34 children were age five or younger; more than half (59 percent) were one year of age or younger. Abusive head trauma was the leading cause of injury or death, accounting for 53 percent of incidents, and abuse or neglect was substantiated in two-thirds of the cases.

Detailed reports are prepared each year, providing information about the victims and the perpetrators of abuse, as well as the recommendations made to mitigate systemic gaps. A link to these reports is provided.

Emergency Response Meetings (ERM): CYF conducts Emergency Response Meetings when there is a child death due to suspected abuse or neglect and/or when a child has been in the custody of CYF within the past 16 months.

CYF convened a total of 66 ERMs from 2009 through 2011. The majority of children were one year of age or younger. The most frequent causes of death were co-sleeping, medical causes, gunshot wound, fire, Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID). Recommendations focused on such issues as community education about child development, gun safety and the dangers of co-sleeping; expansion of placement options for at-risk youth and special needs children; and the risk and safety assessment management process by child welfare staff.

Executive Summary
(continued)

Director's Action Line (DAL): Managed by the Office of Community Relations (OCR), the Director's Action Line provides information, support, referrals and consultation in response to grievances, concerns and complaints reported by consumers, providers and/or staff. During the three-year period covered by this report, the DAL received more than 44,000 calls; more than 90 percent of these calls were requests for information. Other calls concerned complaints about service or about a DHS-contracted service provider, requests for assistance or for a referral to an appropriate service, and safety or maltreatment issues.

Integrated Service Planning Process (ISPP): Coordinated and facilitated by the Executive Office's Integrated Program Services staff, ISPP works to develop, implement and monitor a comprehensive plan for children whose extensive and complex needs require coordinated support from multiple systems. Since 2009, 200 children/families participated in the ISPP, which addresses barriers to successful treatment and recovery for these children and their families. Of the 200 children served, 21 percent were involved in two systems, 53 percent were involved in three systems, and 26 percent were involved in four systems.

Multi-System Rapid Response Team (RRT): The RRT is convened to assist children and youth with complex needs who have not been successfully served within the existing array of DHS services. It is designed to address ongoing systems issues facing this group of children as well as to creatively address individual emergency situations when placement is at risk and other solutions are not readily available. The RRT intervenes when the ISPP cannot be otherwise implemented due to: 1) funding limitations; 2) complex intersystem issues or circumstances such as a history of sex offenses, or severe aggressive or self-injurious behavior; or 3) the existence of multiple disabilities, including fragile medical needs.

Sixteen children, adolescents and their families were assisted by the RRT; appropriate and stable housing was the need addressed with the greatest frequency.

BACKGROUND

In October of 2008, the Allegheny County Department of Human Services (DHS) published a report entitled *Quality Improvement Assessment* that described Quality Improvement (QI) activities taking place throughout DHS. This report identified the existing QI processes of each of the program and support offices, as well as the Executive Office, and analyzed each process's contribution to quality improvement and control within DHS, using the framework of the Council on Accreditation's (COA) Performance and Quality Improvement (PQI) standards. (More information on these standards can be found in Appendix B). One of the key recommendations that emerged from the 2008 analysis was to establish an agency-wide QI process focused on direct services. To make this process as independent and objective as possible, it was recommended that reviews of direct service be conducted by an autonomous team rather than by those directly responsible for providing the service. A QI Team was then assembled within the Office of Data Analysis, Research and Evaluation (DARE) and tasked with implementing QI for direct service, starting with child welfare. DARE's QI activities provide an impartial review of the delivery of direct services within CYF and across other program offices where children and families are served.

[1] Direct services are provided through DHS program offices. Appendix A contains a list of offices and describes the services provided by each.

[2] Casey Family Programs, National Resource Center for Organizational Improvement

Many of the QI activities focused on child welfare services in Allegheny County are driven by the Continuous Quality Improvement (CQI) process that was adopted to drive change in Pennsylvania. The state's CQI approach, defined as "the ongoing process by which an agency makes decisions and evaluates its progress," is an effort to reshape the child welfare system to more fully support the achievement of positive outcomes for children and families.

To support these activities, the state has adopted the American Public Health Services Association's DAPIM™ model of quality improvement, which includes five main steps to facilitating and sustaining change: Define, Assess, Plan, Implement and Monitor:

- **Define** the desired state and what the organization wants to improve by engaging key stakeholders in discussion to strategically identify specific and meaningful issues that system partners are interested in improving.
- **Assess** strengths and gaps in performance capacity, performance actions, outputs and outcomes. This locally driven assessment process is an inclusive one because the achievement of positive outcomes will be realized only when the full resources of a community are garnered.

- **Plan** for quick wins, medium-term improvements and longer-term improvements that leverage strengths and address root causes of gaps. Locally, this resulted in the completion of the Allegheny County Improvement Plan.
- **Implement** plans for maximum impact and sustainability. Successful implementation of these plans required CYF to engage key internal and external stakeholders who actively support the implementation of improvement activities with ongoing technical assistance from the state.
- **Monitor** progress through ongoing evaluation and follow through with CQI efforts. During this phase, CYF engages in monitoring activities that allow for evaluation and measurement of progress and impact. The PA Quality Service Review (QSR) process, conducted jointly by the state and the local community, is the primary mechanism for driving the evaluative process.

This report describes the QI activities that took place from 2009 through 2011 and provides an analysis of the data and recommendations resulting from these activities.

QUALITY IMPROVEMENT ACTIVITIES AND OUTCOMES, 2009–2011

Quality Service Review (QSR)

The QSR is the mechanism through which Allegheny County's practice model and associated standards are measured. DHS's QSR process is based upon PA's *QSR Protocol* and uses an in-depth case review method and practice appraisal process, as well as focus groups, to find out how children, youth and families are benefiting from the services they receive. The QSR case review uses a combination of record reviews, interviews, observations and deductions, including qualitative indicators that measure the current status of the focus child[3] and the child's parents' and/or caregivers' status. PA's *QSR Protocol* is also designed to capture information for the Allegheny County Program Improvement Plan (PIP).

[3] For each of the in-home and out-of-home cases selected for review, one child was selected as the "focus child" about whom reviewers were asked to rate the child-specific indicators.

In May 2010, the PA Department of Public Welfare (DPW) Office of Children, Youth and Families selected Allegheny County as one of the counties in the state to pilot the QSR process as part of its overarching commitment to continuous quality improvement and in response to results of the Child and Family Services Review (CFSR) of 2008. Formally implemented in 2011, QSR is now operational in 11 counties throughout Pennsylvania. Allegheny County uses the results of the QSR to develop a County Improvement Plan (CIP), submitted to DPW, that focuses on system delivery and performance issues. Improvements to existing QI processes, as well as recommendations for the implementation of additional initiatives, are identified in the CIP.

The 2011 Allegheny County QSR was independently evaluated by Hornby Zeller Associates (HZA), a national consulting firm dedicated to promoting practices that enhance the lives of children and families. HZA's reports are published by DPW; the 2011 QSR Report can be viewed at: www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_011055.pdf.

County Improvement Plan (CIP)

Following the 2011 QSR, DHS developed a CIP to address opportunities for improvement derived from the QSR results and from additional administrative data associated with safety, permanency and well-being outcomes. The CIP was approved by DPW and posted to its website (www.dpw.state.pa.us).

Three areas of improvement were identified for inclusion in the 2011 CIP: 1) Permanency; 2) Engagement of Fathers; and 3) Teaming (Family Team Conferencing).

The responsibility for implementation of the CIP is divided among three teams of front-line staff who work with children and families. The Sponsor Team is responsible for approving the plan at the county level, high-level planning for CQI efforts, and securing resources for improvement efforts. The Implementation Team maintains responsibility for day-to-day CQI activities and oversees smaller CQI work groups. The Implementation Team is also responsible for developing the individual action steps that are the focus of the work groups. Three work groups were developed to focus on the three areas; these groups have been working since the fall of 2011 to gather research and ideas, implement action steps, and develop recommendations in their assigned area.

The following summarizes actions related to the 2011 CIP outcome areas:

Improved Permanency

- A Re-entry to Care study was conducted by the Department of Data Analysis, Research and Evaluation (DARE) to analyze successful and unsuccessful exits through in-depth case reviews and interviews with parents, caregivers and caseworkers. This study identified the need for improved discharge and transition planning, which will continue to be explored through ongoing qualitative and quantitative reviews.
- Allegheny County, in partnership with Casey Family Programs, will implement the Casey Permanency Roundtable process in fall 2012. Ongoing planning to identify appropriate cohorts for review began in 2011.
- CYF implemented the Safety Assessment and Management Process as a component of safe case closure and prevention of re-entry.
- CYF developed appropriate policies and conducted additional training to improve safety assessment, service plans and visitations.

- DHS plans to fully implement Safe Measures, a case management/reporting tool developed by the Children's Research Center to support ongoing accountability and quality improvement, by the end of 2012. Supervisors and caseworkers will be able to use this tool to improve case practice.
- The state issued a "Concurrent Planning Bulletin" in May 2012, and CYF will complete a self-assessment of existing concurrent planning efforts in accordance with this bulletin.
- A case review process is in development to replace the NGA review process as a monthly review of system and case practice issues. CIP improvement priority outcome areas will be the focus of this review process, which will measure both quantitative and qualitative elements.

Improved Engagement of Fathers

- DARE completed an analysis of data elements related to fathers to aid in clarifying available and recommended father-specific data. Additional policy and training recommendations relating to documentation and data tracking will be developed.
- New training on the Family Finding™ model began in October 2011 to assist with location of family members, including fathers.
- A Family Engagement Unit within CYF was developed to conduct searches for family members available to assist in placement, to notify relatives of placement, to participate in family engagement meetings, and to participate in Permanency Planning Conferences.

Improved Teaming (Family Team Conferencing)

- Planning for and implementation of the Family Team Conferencing practice model began in 2011. During this process, the family is engaged in decision-making, goal-setting, and achieving outcomes of safety, well-being and permanency. Continued training and implementation of this model will help achieve DHS's goal of implementing Family Team Conferencing with all families within five years.

NATIONAL GOVERNORS ASSOCIATION (NGA) QUALITATIVE CASE REVIEWS

Background

Pennsylvania was one of six original states selected through a competitive application process to participate in the NGA Policy Academy on *Safely Reducing the Number of Children in Foster Care*. The NGA is a bipartisan organization of the nation's governors that promotes visionary state leadership, shares best practices, and speaks with a unified voice on national policy.

The NGA Policy Academy developed a two-year strategic plan, including a framework for assessing progress to safely reduce the number of children in foster care. The plan focused on the goals of reducing the number of children entering care, shortening length of stay for those in care, and/or improving permanency outcomes to reduce returns to care. The specific goal of the NGA Policy Academy in Pennsylvania was to safely reduce foster care placements by 15 to 20 percent by the year 2010. From January 2009 through December 2010, Allegheny County CYF accomplished an 11 percent decrease in out-of-home placements. Though Allegheny County did not reach the goal of 15 to 20 percent reduction in placements, considerable progress was made during this period. DHS implemented and expanded a number of programs designed to improve permanency outcomes, and the NGA case reviews provided a forum for identifying systemic issues that impeded permanency. A number of policy and training recommendations were made during the NGA reviews; these are summarized below.

In an effort to identify systems issues and case practice issues that impede permanency or result in avoidable entries or re-entries, the Allegheny County QI Team coordinated the monthly NGA case presentation process. A standing committee was chaired by DPW's Deputy Secretary of the Office of Children, Youth and Families and the DHS Executive Director, and included other state child welfare representatives, including:

- Representatives from the Western Region of Pennsylvania DPW's OCYF
- Allegheny County DHS leadership
- DHS Deputy Director of CYF and other CYF leadership and casework staff
- Court personnel, including the Administrator, Deputy Administrator and Child Protection and Permanency Manager of Allegheny County Children's Court
- Representatives from the Allegheny County Solicitor's office
- Personnel from the Pennsylvania Child Welfare Resource Center (formerly the Pennsylvania Child Welfare Training Program)
- Representatives of the Statewide Adoption and Permanency Network (SWAN)

In addition to the standing committee, caseworkers and community-based providers specific to each case were invited to the meeting to present case-specific information. Other representatives from DHS were invited when a need for their knowledge or services was identified in advance.

The QI Team conducted case record reviews of selected cases from each regional office and collaborated with casework staff and providers to identify systems-wide and case practice issues that may have impeded achieving permanency for children in care. The team also prepared a briefing that summarized key facts of the case. In addition to case reviews, NGA reviews also involved presentations of data related to child welfare indicators, including referral data, re-entry data, and other information that informed the discussion.

Each month, at least four cases were chosen from one regional office. Reviews took place at the office from which the cases were selected, providing the review team the opportunity to see the offices in which CYF operates and to receive firsthand accounts from staff providing direct services.

Initially, cases were selected from the categories of "entering care," "exiting care," "goal of adoption," and "in care six months or longer." After several months of reviews, members of the team requested that one of the four cases from their office be a case with difficulty with permanency goal attainment because of system or case practice issues.

As more cases were brought to the review team through these means, it became clear that identifying cases with particularly challenging case practice and system issues resulted in reviews that identified critical issues and allowed the team the opportunity to address those issues.

NGA reviews covered all five regional offices (North–NRO, South–SRO, East–ERO, Central–CRO and Mon Valley–MVRO), the Adoption/Foster Care (AFC) office, and the Lexington Intake Office (LIO).[4] The NGA Team reviewed 84 family cases from 2009 through March 2011; these cases included 177 focus children (102 boys and 75 girls). In addition to the 177 focus children, QI staff reviewed 161 siblings of target children: 41 in placement at the date of the review, 90 who had never been in placement, and 27 who were not currently in care but had been previously.

[4] Adoption/Foster Care (AFC) cases have been included in regional office statistics for the purposes of this report.

Data Analysis

Among the subject children reviewed through the NGA process, a range of ages and races was represented. As shown in **Table 1**, the majority of children were African American, with small numbers of children who were biracial, other or for whom race was not known. A small number of children under the age of one were reviewed. Most children were in the five- to nine-year-old age range, with significant numbers of children also reviewed in the one to four age range and the 10 to 14 age range.

TABLE 1: **Race of Children Reviewed through NGA Process, 2009–2011**

RACE	TOTAL
African American	113
White	47
Two or More Races	12
Other/Unknown	5
Total	**177**

TABLE 2: **Age of Children Reviewed through NGA Process, 2009–2011**

AGE	N = 177
Under 1 year	8
1–4 years	50
5–9 years	45
10–14 years	40
15 and above	34
Total	**177**

Figure 1 identifies the out-of-home placements in which the subject children were living at the time of review. Most of the children and youth reviewed during this period were in foster home placements (46 percent); a high number were also in kinship placements (23 percent). When children are placed in out-of-home care, every attempt is made to keep siblings together and to provide kinship care, that is, to place them with relatives or close friends within their home communities.

FIGURE 1: **Type of Placement: 2009–2011**

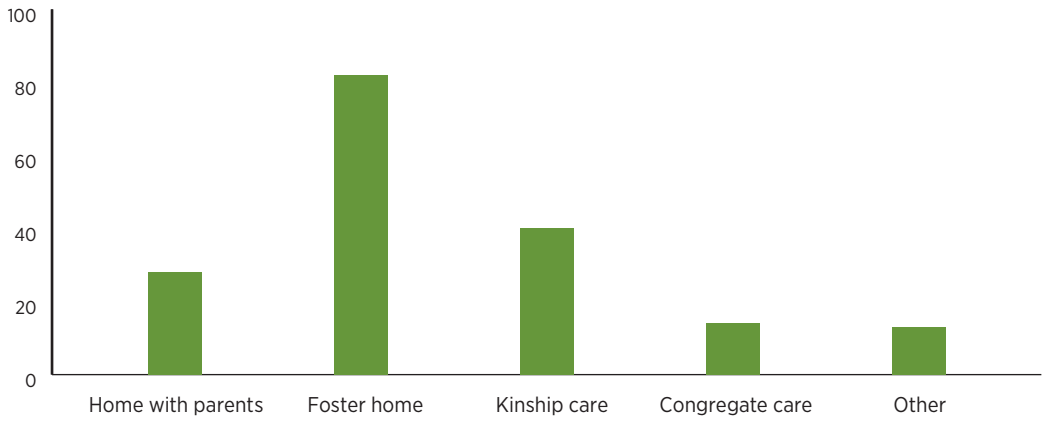
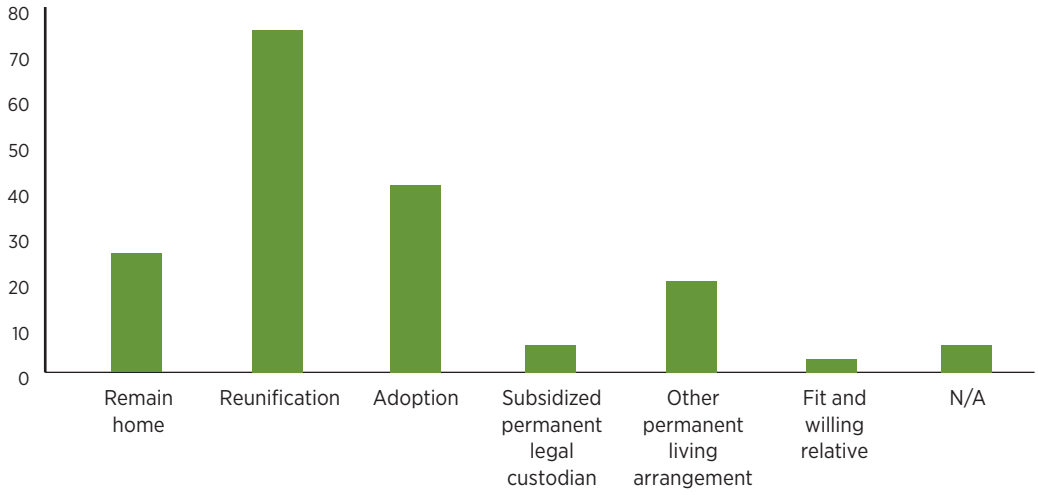


Figure 2 shows the court-determined permanency goal for the children targeted for review. The following abbreviations are used on the chart: Subsidized Permanent Legal Custodian (SPLC), Other Permanent Living Arrangement (OPLA), and Placement with a Fit and Willing Relative (FWR). The children whose goal is not applicable represent cases reviewed under the "exit from care" category and also those children whose case had not been accepted for services during the review of the intake office. Most of the children's goals were to return home, with adoption following as the second most common goal.

FIGURE 2: **Court-Determined Permanency Goal for Children Targeted for Review, 2009–2011**



Recommendations and Outcomes

NGA reviews identified case practice issues and system barriers that impede timely child welfare permanency, resulting in the recommendations summarized below:

1. **CYF to enhance the timeliness of adoption matching once a referral is received in the Adoption Department.**
    - CYF issued Procedural Memorandum on Permanency Planning Conference Protocol for all families in which at least one child or youth is in foster care and reunification is not expected to occur within 30 days (December 2010). Permanency Planning Conference protocol requires attendance and participation by Adoption, Family Group Decision Making (FGDM), Foster Care and Independent Living Initiative staff of record.
    - Transition plan is required for all youth aging out. Memo available in KIDS electronic case management system (May 2009).
    - Revision of CYF Policy on Permanent Legal Custody agreements that are more individualized to reduce barriers to legal permanence (June 2011).

- State legislation passed that created a Subsidized Permanent Legal Custodianship (SPLC) and expanded the definitions of relative and child under the Kinship Care guidelines (July 2012). This legislation permits adoption subsidy or SPLC to continue for a dependent child until age 21 if certain criteria are met, and provides resources to willing caregivers and relatives, enabling them to afford to commit to providing forever homes for children.
- CYF issued Procedural Memorandum regarding Act 101 Implementation (April 2011). CYF must provide notice for prospective adoptive parents and birth relatives to enter into a voluntary, enforceable agreement for continuing contact post adoption.
- Development of a Diligent Search and Family Engagement Unit to locate family members who can be approved as foster parents to avoid emergency placement of children in homes uncertified and unapproved by the Court because no other relative home is readily available (planning process ongoing).

2. **CYF to develop working relationship with school districts to ensure educational planning for children as critical life domain.**
   - All CYF staff received training from the Pennsylvania Child Welfare Resource Center regarding the new statewide Educational Screen Policy issued January 2012 (May 2011). The Educational Screen is a tool designed to ensure compliance with the Fostering Connections Act and other federal laws for children in care, specifically around barriers to achieving positive educational outcomes.
   - Implementation of a data-sharing agreement between the Pittsburgh Public Schools (PPS) and DHS permitting integration and analysis of student data from the schools, human service agencies, juvenile justice, DPW and other sources, allowing for a deeper understanding of the circumstances surrounding students of mutual interest and presenting opportunities to develop better-informed strategies and interventions to improve student outcomes. Directory-level information is published in DataVue, a DHS database of county services provided to Allegheny County consumers (2010).

3. **CYF to conduct a thorough assessment of parental substance abuse and its impact on the safety and well-being of children and to develop a safety plan, when appropriate, prior to consideration for removal.**
   - CYF issuance of Procedural Memorandum regarding obtaining drug and alcohol assessment for parents prior to court hearings (April 2010).

4. **CYF to enhance training related to confidentiality of Family Finding (identifying other resources within the family based on federal law and mandated by Fostering Connections to Success).**
   - All CYF casework and administrative staff received training in the Family Finding™ Model (October 2011 to May 2012). Allegheny County has operationalized concepts from the model into a tailored approach for CYF.

5. **Solicitors to review automatic pursuit of Aggravated Circumstances,[5] as Termination of Parental Rights may be denied if reunification services are not provided.**

6. **CYF casework staff to be advised to assist resource families to transfer knowledge to birth parents or other guardians upon a child's return home from resource care.**

[5] The child is in the custody of a county agency and either: the identity or whereabouts of the parents is unknown and cannot be ascertained, and the parent does not claim the child within three months of the date the child was taken into custody; or the identity or whereabouts of the parents is known and the parents have failed to maintain substantial and continuing contact with the child for a period of six months; or the child or another child of the parent has been the victim of physical abuse resulting in serious bodily injury, sexual violence or aggravated physical neglect by the parent; or the parent of the child has been convicted of offenses where the victim was a child.

ACT 33 OF 2008 CHILD FATALITY / NEAR-FATALITY REVIEWS

Background

On July 3, 2008, Pennsylvania Governor Edward G. Rendell signed Act 33 of 2008 into law. An amendment to the Child Protective Service Law (CPSL), Act 33 requires that circumstances surrounding cases of suspected child abuse resulting in child fatalities and near-fatalities be reviewed at both the state and the local levels. Allegheny County has embraced the legislative mandates of Act 33 through the implementation of a local Child Fatality / Near-Fatality (CFNF) review process. Act 33 reviews seek to identify systematic changes that will lead to improvements in service delivery to the children and families of Allegheny County. In addition, these reviews add greater transparency and accountability to DHS's review process by granting the public access to information related to each child fatality or near-fatality when abuse is suspected.

The Act 33 CFNF review team is chaired by a physician with a national reputation in the field of child abuse and neglect, and meetings are facilitated by a Professor Emeritus from a renowned regional university with extensive experience in child welfare practice and research. The standing team members represent a cross-section of multidiscipline experts in the field.

The standing team includes:

- DHS Executive Director
- CYF administration, including Deputy Director and Assistant Deputy Director
- Medical Examiner's Office
- Representatives of the District Attorney's office
- Court personnel
- Community providers with specialty in family violence
- Members of the CYF Advisory Board
- Representatives from the legal community
- Other key DHS representatives with experience in the child welfare and behavioral health systems

The QI Team is responsible for collecting and analyzing case information for the review process within 30 days of the report of the incident. The process includes a qualitative case record review of current and historical child welfare involvement, review of provider reports related to the family, research of DHS databases to identify other system involvement, and review of available medical and service records (physical health and medical examiner records, where applicable). DARE staff also conduct interviews with CYF staff and providers, as well as other DHS system partners who have involvement and/or expertise in the issues identified through case review. The Act 33 Review Team reviews information and issues presented by the QI Team at a monthly review meeting, identifies systems' issues that require attention, and generates recommendations related to those identified systems' issues. The review findings and recommendations are presented to the state within 90 days of receipt of the report, detailing the incident, the scope of the review, the safety plan and services in place for the family, and recommendations that will assist in future cases.

Data Analysis

From 2009 through 2011, 34 incidents were reviewed by the CFNF Team: 13 child fatalities and 21 near-fatalities.

- The number of fatalities and near-fatalities in 2011 (15) increased as compared to the previous two years (a total of nine in 2009 and ten in 2010).
- While the incidence of near-fatalities held steady at seven annually, the incidence of fatalities increased from two in 2009 to three in 2010 and eight in 2011.
- Half of the families involved in these incidents were known to CYF.
- Abusive head trauma was the leading cause of injury or death, accounting for more than half (53 percent) of the children.
- Abuse or neglect was substantiated in two thirds of the cases.
- The majority of children (30 of 34) were age five or younger; 59 percent were age one or younger. Only two teenagers suffered death or serious or critical injury due to suspected maltreatment.
- Seventy percent of the children were male. In terms of race, 41 percent were white; 32 percent were African American; 21 percent were multi-racial; and for six percent (two), race was not identified in the CYF record as it was not volunteered by the family.
- Perpetrators of abuse were parents, caregivers or intimate partners; 76 percent of fatal or near-fatal incidents took place in the homes of birth parents.

The majority of substantiated perpetrators (72 percent) were known to child welfare as children; 62 percent had a documented history of domestic violence; 56 percent had a criminal history; and 56 percent had previous involvement with the behavioral health system.[6]

[6] We understand a history of behavioral health involvement to be one or more of the following: (i) a confirmed mental health or Drug and Alcohol diagnosis; (ii) current or past participation in clinical treatment; and/or (iii) self report of current or past participation in behavioral health services.

An annual report is prepared on the findings from the Act 33 CFNF reviews. These reports are published on the DHS website and can be viewed at: www.alleghenycounty.us/dhs/research.aspx

Recommendations

The Act 33 Team made recommendations over this period to address systemic issues identified during the Act 33 CFNF review process. These recommendations, as well as the steps taken to address the issues, can be found in the detailed CFNF reports. Examples of the type of recommendations addressed by the team follow:

Community Education and Child Safety

- The team lauded Staunton Farm Foundation for making parents of every baby born in Allegheny County hospitals during 2010–2011 eligible to receive a free DVD instructing parents on effective ways to soothe their crying babies. *When Your Baby Cries…Ways to Soothe Your Baby*, is a video created by Fred Rogers Company for A Child's Place at Mercy Health Systems as part of The Infant Crying Project.
- The Allegheny County Health Department issued a Web-based press release, "Stopping Unintentional Shooting Starts with Gun Education," reminding residents that unintentional firearm deaths, especially involving children, can be prevented by taking simple precautions. Those precautions are listed on the Health Department's website (August 2011).
- Children's Hospital of Philadelphia granted permission for DHS to post on its website and to reprint the hospital's gun safety brochures, *Gun Safety: A Monster in the Closet is the Least of Your Concerns* and *Seguridad con las armas de fuego — Un monstruo en el armario es en realidad su menor preocupación*, offering suggestions for staying safe when firearms are present in living quarters.
- In recognition of Child Abuse Prevention Month, DHS launched the *Choose Your Partner Carefully…Your Baby is Counting on You* campaign, in collaboration with Family Resources and Pittsburgh Mercy Health System and with the support of other community partners, to raise awareness about prevention of child abuse. The campaign was created to remind parents that choosing an appropriate caregiver for a child, including a care-giving partner, is one of the most important decisions a parent can make. Campaign materials — brochures, posters, flyers and bus cards — are available on the DHS website and have been distributed locally and across the state by community partners (March 2011).

Co-Sleeping

- The Allegheny County Health Department issued Web-based guidelines for health care professionals, *A Safe Sleep Environment for Infants*, in an effort to ensure that safe-sleep education for parents and other caregivers is consistent and repetitive and that child care providers, home visitors and other stakeholders will reinforce the core elements of the safe-sleep description when interacting with parents and other caregivers.

- DHS issued the *ActionAlert — Safe Sleep Education* and the Safe Sleep Leave-behind Flyer to inform staff and caregivers about these dangers and how to reduce them. *ActionAlert — Safe Sleep Education* outlines safe-sleep guidelines and the Department's expectations for all DHS and provider staff members working with parents and/or caregivers of infants. The goal is to reduce infant deaths associated with unsafe sleep practices (2009).
- A variety of educational products about the dangers of co-sleeping (door hangers, brochures, etc.) have been and continue to be distributed at community and legislative fairs. Additionally, letters about the dangers of co-sleeping were twice sent to providers and other community partners; these letters included samples of the educational products and an order form.
- With the cooperation of the Area Agency on Aging, brochures were distributed in senior centers, targeting grandparents in an effort to increase their knowledge about the dangers of co-sleeping.
- CYF provision of Pack 'N Play secure play/nap areas to families without cribs to mitigate risk of co-sleeping fatalities (ongoing).

Safety Assessment Management Process

- CYF reissued Policy Memoranda on response time; CYF casework staff trained on response time (2011). Administrative review of Field Screen Policy ongoing.
- All CYF staff at regional offices completed training on both DataVue, a DHS database of county services provided to Allegheny County consumers, and on diligent search methods for families whose whereabouts are not immediately known (May 2012).
- CYF casework staff received additional training on: development of individualized, assessment-based Family Service Plans; Child and Adolescent Needs and Strengths assessment tool; and Safety Assessment Management Process (May and June 2012).
- CYF administration and internal quality assurance staff reviewed internal and external case closure documents and found that they align. Established protocol are regularly reviewed during Permanency Planning Conferences; at trainings, NGA and other interdisciplinary team reviews; and at supervisory reviews, as well as at orientation and ongoing training (required) for all casework staff.
- State Training Documents on Safety, Risk, Case Closure and Case Closure for Sexual Abuse have been posted to a networked policy portal for CYF casework staff to review for guidance, and FGDM's and Inua Ubuntu's Case Closure Guidelines are shared with provider staffs.
- All CYF casework staff received additional training on risk and safety assessments and plans, service selection and provision, to further reinforce case closure guidelines (October 2011).
- KIDS electronic case management User Manuals and Job Aids have been developed and updated to assist casework staff in data entry.

- CYF administration issued a Practice Memorandum with revised directions on visiting children at home and in foster care, standards for frequency of visits with infants, and tiered management solutions to help staff correctly track visits with children (April 2010).
- In an effort to assist in decision-making, the CYF Training Department developed a Safety Assessment Management Process checklist, which has been posted for staff use until the state issues final guidelines.
- DHS is in the process of implementing Safe Measures, a case management/reporting tool developed by the Children's Research Center and designed to support ongoing accountability and quality improvement processes. Using this tool, CYF supervisors and caseworkers will monitor their work to ensure compliance with local case practice standards, as well as with state and federal standards to measure outcomes.

EMERGENCY RESPONSE MEETINGS (ERM)

Background

ERMs are convened in response to child deaths as recommended by the Pennsylvania Standards for Child Welfare Practice published in January 2000. The QI Team participates in these meetings, which are coordinated and facilitated by CYF in any instance of child death due to suspected abuse or neglect and/or when a child is in the custody of CYF currently or if the family has been known to the agency within the past 16 months. In cases where CYF is currently involved or has been within the past 16 months, there is overlap between the Act 33 CFNF review process and ERM.

The attendees at these meetings review internal practices and procedures to identify case decision-making practices and areas in which systemic change may be warranted.

The ERM Team is made up of the following members:

- Deputy Director of CYF
- Assistant Deputy Director of CYF
- CYF Regional Office Directors, including Regional Office Director of record on the case
- CYF Director of Training
- CYF Supervisor of record
- CYF Caseworker of record
- Case Practice Manager (who also serves as the meeting Facilitator)
- Case Practice Specialists
- CYF Advisory Board members
- Quality Improvement Manager for DHS

Data Analysis

From 2009 through 2011, ERM convened meetings on a total of 66 child deaths. African Americans made up 63 percent of the children who died, and 58 percent of the children were male. As was the case in the Act 33 Reviews, the majority of children reviewed at ERM were one year of age or younger. The cause of death for the cases reviewed by ERM are shown in **Figure 3**.

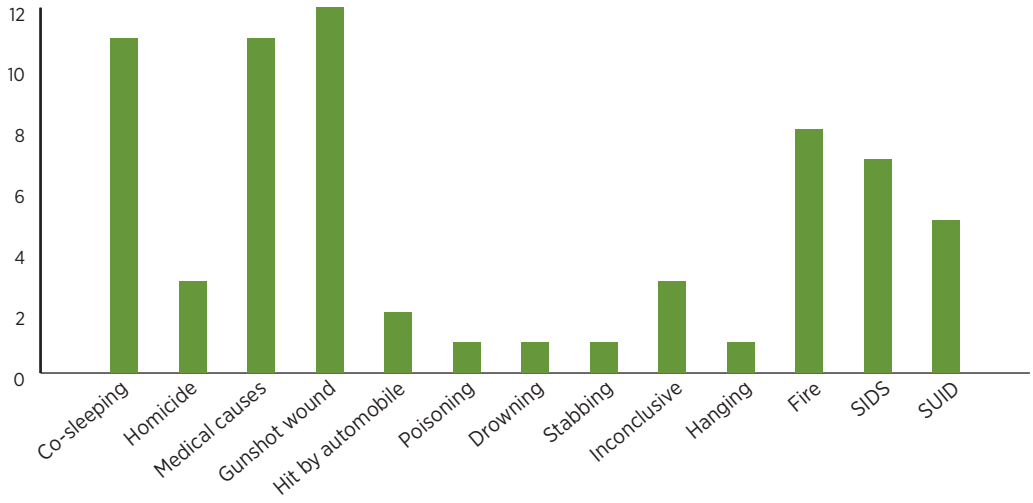
TABLE 3: Race and Sex of Children Reviewed at ERM, 2009–2011

RACE	FEMALE	MALE	TOTAL
African American	17	24	41
White	10	9	19
Two or more races	1	4	5
Not volunteered	0	1	1
Total	**28**	**38**	**66**

TABLE 4: Age of Children Reviewed at ERM, 2009–2011

AGE	N = 66
One year or younger	39
2–5 years	8
6–12 years	8
13–17 years	11
Total	**66**

FIGURE 3: Causes of Death Reviewed at ERM, 2009–2011



Recommendations and Outcomes

The ERM Team makes recommendations based on the reviews it conducts in order to improve case practice and services to families, address system issues, and prevent future child deaths when possible. Services provided to the families included referrals for grief counseling, substance abuse treatment, parenting programs, Family Group Decision Making, gang/crime diversion programs, truancy prevention programs, housing assistance, and provision of concrete goods for families. Systemic recommendations made by the team over the three-year period are listed in Appendix C.

DIRECTOR'S ACTION LINE (DAL)

Background

DAL is DHS's mechanism for addressing complaints and requests from consumers. Grievances about or from consumers, staff and providers are also handled through DAL. DAL responds to these complaints in partnership with direct service staff and their supervisors. Through DAL, Allegheny County residents have access to knowledgeable specialists who are able to answer questions and troubleshoot grievances, concerns and complaints regarding services provided through DHS.

Since 1998, DAL has responded to calls about all services provided or contracted by DHS:

- Child protective services
- Services for children and families
- Services for older adults
- Services to protect older adults from abuse or exploitation
- Services for children and adults with mental health concerns
- Services for youth and adults with substance use disorder concerns
- Services for incarcerated parents of dependent children
- Services for people with intellectual or developmental disabilities
- Hunger services
- Housing services
- Energy assistance
- Non-emergency medical transportation

In 2009, DAL began processing and investigating contract violation complaints made by CYF staff against CYF-contracted providers. At the same time, efforts were made to decrease the number of complaints and questions related to CYF by ensuring that parents of children referred to CYF received their Parent Handbook as required by DHS policy. DAL receives a list from the CYF Lexington Intake Office of all CYF consumers accepted for services, to determine whether or not they received the handbook. If a handbook has not been received, DAL mails a copy.

Currently, DAL provides the following services:

- **Consultation.** A conversation with a trained professional to listen to the details of a consumer's situation or caller's concern
- **Referrals.** Suggestions about where a consumer or caller might find help for his or her situation
- **Support.** Realistic options to resolve difficulties
- **Information.** About DHS and community-based resources and services
- **Clarification.** Help in understanding DHS policies and procedures, including DHS service plans and court orders through Children's Court
- **Resolution.** Support in resolving problems with DHS-issued payments
- **Follow-up and distribution of Parent Handbooks.**

The DAL specialist can initiate a review of service decisions made by any DHS Office or program or any DHS-contracted agencies. Specialists work with DHS staff and others to promptly troubleshoot concerns or complaints. All concerns and complaints are recorded so that they may be used to evaluate DHS policies and procedures.

Data Analysis

Total Number of Calls

There were 52,673 calls from 2009 through 2011 (see **Table 5**).

- The average number of calls per day ranged from 52 to 65; cases accepted per day ranged from six to seven.
- The average number of contacts per week ranged from 271 to 301.
- The average number of information and follow-up calls per week ranged from 211 to 240.
- From 44 to 49 percent of calls per year represented new complaints.

Types of Calls

DAL receives and makes the following types of calls:

- Follow-up and informational calls made by DAL staff or to DAL staff
- Follow-up calls to investigate concerns and obtain more information for consumers. A call deemed an "Accepted Complaint/Request" has been recorded and investigated
- When the DAL specialist has completed his or her involvement, the call is then categorized as a "Closed Complaint/Request"
- Calls initiated by a CYF staff member regarding a concern with a DHS-contracted agency are categorized as either an "Open Non-Compliance" or a "Closed Non-Compliance" call

- The Parent Handbook is provided to every family by a caseworker as families enter the Allegheny County child welfare system. It outlines the rights and responsibilities of parents and provides an overview of what CYF involvement entails

TABLE 5: DAL Calls by Type, 2009–2011

CALLS	2009	2010	2011	TOTAL
Follow-up and informational	12,821	15,658	12,796	41,275
Complaints or requests	1,406	1,581	1,577	4,581
Non-compliance	158	92	93	343
Parent Handbook	2,605	2,252	1,634	6,491
TOTAL	**19,990**	**19,583**	**16,100**	**52,673**

Complaint and Request Calls by Program Office

Part of tracking DAL calls includes categorizing complaints and requests by office and department. **Table 6** summarizes the complaints and requests made to DAL by the program office under which they fall. Due to the nature of the work CYF does and the fact that it is the DHS program office that has the most employees working directly with consumers, it can be expected to have higher levels of complaints and requests.

TABLE 6: Complaint or Request Calls by DHS Office, 2009–2011

	2009	2009	2009	2010	2010	2010	2011	2011	2011
	Complaints	Requests	TOTAL	Complaints	Requests	TOTAL	Complaints	Requests	TOTAL
Administration	8	9	**17**	7	4	**11**	15	6	**21**
Aging	21	22	**43**	34	27	**61**	26	38	**64**
Children, Youth & Families	815	139	**954**	810	162	**972**	736	184	**920**
Behavioral Health	70	31	**101**	95	35	**130**	99	32	**131**
Community Relations	3	8	**11**	2	23	**25**	3	32	**35**
Community Services	53	15	**68**	75	34	**109**	46	42	**88**
DARE	0	0	**0**	0	1	**1**	0	1	**1**
DHS	1	4	**5**	0	4	**4**	0	13	**13**
Executive	1	0	**1**	0	0	**0**	0	1	**1**
Intellectual Disability	75	25	**100**	48	18	**66**	58	22	**80**
Resources External to DHS	33	73	**106**	6	196	**202**	44	179	**223**
TOTAL	1,080	326	**1,406**	1,077	504	**1,581**	1,027	550	**1,577**

Common Themes

A wide variety of consumer concerns, suggestions and requests are addressed by DAL; the following issues have remained consistent over the three-year period:

- Health and/or Safety Concerns
- Staff Attentiveness/Responsiveness
- Request for Information
- Dissatisfaction with Services or Decision by Caseworker or Direct Service Staff
- Consumer Rights
- Visitation
- Placement-Related Issues
- Housing Issues
- Contract Violation
- Dissatisfaction with Contracted Service Providers
- Maltreatment/Neglect/Safety Issues
- Payment/Fiscal
- Staff Sensitivity
- Staff Conduct
- Transportation

Conclusion

The DAL is a well-used mechanism for consumer feedback and concerns. Annually, over the three-year period, DAL has resolved well over 90 percent of consumer complaints and requests. The QI Team will continue monitoring DAL trends to identify emergent issues and maintain a high level of consumer satisfaction.

INTEGRATED SERVICE PLANNING PROCESS (ISPP)

Background

In early spring 2011, ISPP, formerly referred to as the Interagency Review Process, was enhanced to reflect a more integrated approach to service planning across DHS program offices that serve children and families. When there are complex issues and barriers to successful treatment and recovery, the Integrated Service Planning Process (ISPP) is an opportunity for families and children to meet with those who are involved in their care to develop and implement a comprehensive plan of action to resolve these issues. ISPP is unique in that it gathers various child-serving systems and resources to address what are often complicated matters that involve more than one system. Enhanced components also include the involvement of Youth Support Partners, Family Support Partners and services for transition-aged youth.

ISPP is coordinated and facilitated by the Executive Office's Integrated Program Services staff. The quality improvement component is independently conducted through DARE and includes data collection and analysis of identified service gaps, of changes in needs, and of youth and family satisfaction with the process and outcomes.

Meetings are attended by: family members and the child or youth; DHS Executive Office staff; staff from OBH, OID and CYF, as appropriate; Child and Adolescent Crisis Team Intervention Services from WPIC; service coordinators; community providers; and other natural supports that may be identified by the family.

The process results in the creation of a Joint Service Agreement; this single coordinated plan includes goals for overall care, health, and educational and vocational planning, as well as the development and maintenance of a support system. The Joint Service Agreement mitigates duplication of services while focusing on the strength of the child and family to coordinate services. To ensure that the plans in the agreement are implemented after the meeting, the ISPP Liaison conducts follow-up communication with families and participants.

Data Analysis

Table 7 shows the multi-system involvement of the 200 children served from 2009 through 2011.

TABLE 7: **ISPP Activity by Year, 2009–2011**

	2009–2010	2010–2011
Children served	101	99
Meetings held	110	117
Child	24% (two systems)	17% (two systems)
Multi-system	47% (three systems)	59% (three systems)
Involvement	29% (four systems)	24% (four systems)

MULTI-SYSTEM RAPID RESPONSE TEAM (RRT)

Background

The Multi-System Rapid Response Team (RRT) is convened to assist children and youth who have complex needs but who have not been successfully served within the existing array of mental health, intellectual disabilities, child welfare and juvenile justice systems due to a number of unusual circumstances (e.g., history of sex offenses; severe aggressive, assaultive or self-injurious behavior; limited cognitive functioning combined with severe behavioral disorders; and multiple disabilities, including fragile medical needs). Many young people served by the RRT exhibit a combination of these concerns.

The RRT comprises decision-makers from multiple systems within DHS and the behavioral-health managed-care organization. Its function is to identify trends and gaps in services, implement proactive planning and tracking, facilitate the development of resources, and, when no existing solution is available, meet to plan for a child who is at imminent risk of losing his or her placement.

Data Analysis

For fiscal year 2009–2010, nine children, adolescents and their families were assisted by the team. Of those nine children and adolescents, the RRT Team facilitated placement into Allegheny County's RESPOND Program for four children; three children secured services in various residential programs through the Office of Intellectual Disability; one child secured housing at a behavioral health residential program; and one child received various supportive services.

Seven children, adolescents and their families were assisted by the team during fiscal year 2010–2011. The most common need for these children upon referral to the team was the need for appropriate and stable housing.

Six of the seven children (86 percent) fell into this category.

APPENDIX A

DHS Program Offices Providing Direct Services

When DHS was created in January of 1997, it was organized into an Executive Office, five offices that provided services to the public (program offices) and three offices that supported the entire department (support offices). The distinctions between offices were determined by the types of services they provided. Since 1997, the Executive Office and the Office of Community Relations (OCR) have been expanded beyond a support function to also provide services to county residents. The Office of Data Analysis, Research and Evaluation (DARE) was added as a support office in 2008.

In April of 2010, the Office of Administration was consolidated with the Office of Information Management to form the Office of Administrative and Information Management Services (AIMS). Also in 2010, the name of the Office of Mental Retardation/Developmental Disabilities was changed to the Office of Intellectual Disability (OID).

Office of Administrative and Information Management Services (AIMS)
Provides administrative and information-management support services for DHS and its offices, staff and service providers. In April 2010, incorporated the Office of Information Management as the AIMS Bureau of Information Systems Management.

Area Agency on Aging (AAA)
Provides services to adults age 60 years and older to help them maintain their independence and safe, healthy lifestyles.

Office of Behavioral Health (OBH)
Provides supports for services to adults, young adults and children with mental illness and/or substance use disorders.

Office of Children, Youth and Families (CYF)
Mandated by law to protect children from abuse and neglect. Provides a wide range of preventive, protection and supportive services to work with children and families, with emphasis on family preservation. Provides direct services through caseworkers, case aides and a network of contracted agencies.

Office of Community Relations (OCR)
Responsible for strategic communications and public education efforts for the Department of Human Services.

Office of Community Services (OCS)
Provides services, programs and opportunities that enable low-income and vulnerable individuals and families in Allegheny County to become more self-sufficient.

Office of Data Analysis, Research and Evaluation (DARE)
Supports and conducts research to produce community-ready information about the work of DHS.

Executive Office
Responsible for directing the overall policy, administration and operation of DHS, its offices, programs and services, and for ensuring that the department meets the human service needs of Allegheny County residents. Members of the DHS executive office staff also provide leadership and support for various multi-system, collaborative efforts.

Office of Intellectual Disability (OID)
The County's public office responsible for providing Allegheny County residents with a coordinated, community-focused system of high-quality and cost-effective services, programs and opportunities that enable those with intellectual disability to live according to the principles of self-determination. OID provides services for citizens with intellectual disability through assessment, coordination of treatment, habilitation and support services.

APPENDIX B

Council on Accreditation (COA) Performance and Quality Improvement (PQI) Standards

COA promotes a broad-based, agency-wide process inclusive of staff and stakeholders as a vital, necessary management tool. The PQI standards reflect what experts know about what it takes to start, and maintain, a useful quality improvement program. Taken together, the standards include practices that counter the tendency of agencies to place responsibility for quality improvement and results on one or a few individuals. As such, the standards recognize the value of involving staff at all levels of the agency.

COA's PQI standards provide significant guidance directed at the role of leadership, support for measurement, use and communication of improvement results, and staff training and support practices that reach the full agency. The standards promote wide support and full participation in the improvement process.

The PQI standards support the following practices:

- **Leadership Endorsement of Quality and Performance Values.** The agency's leadership promotes a culture that values service quality and ongoing efforts by the full agency, its partners and contractors to achieve strong performance, program goals and positive results for service recipients.
- **Existence of a Foundation for Broad Use of PQI.** The infrastructure that supports performance and quality improvement is sufficient to identify agency-wide issues, implement solutions that improve overall efficiency, and promote accessible, effective services in all regions and sites.
- **Support for Performance and Outcomes Measurement.** An inclusive approach to establishing measured performance goals, client outcomes, indicators and sources of data ensures broad-based support for useful performance and outcomes measurement.
- **Analyzing and Reporting Information.** The PQI plan describes how measurable data will be obtained and used on a regular basis to further monitor actual versus desired outcomes.
- **Use and Communication of Quality Information to Make Improvements.** Findings based on improvement efforts are disseminated to personnel and stakeholders and are used to improve programs and practice.
- **Staff and Stakeholder Support.** Staff and stakeholders receive information and support that increases their capacity to participate in, conduct, and sustain performance and quality improvement activities.

APPENDIX C

ERM Systemic Recommendations and Outcomes, 2009–2011

AREA	RECOMMENDATIONS AND OUTCOMES
Education and Training	• Develop a campaign to educate families about safe sleeping practices • Public awareness campaign related to children and traffic safety • Training for casework staff regarding assessment and treatment • Public education on gun safety • Promotion of water safety courses and swimming classes
Assessment and Understanding	• Implementation of a policy requiring weekly home visits to all active families with a child under the age of one • Family Finding to find appropriate placements and/or supports for families • Immediate administrative review of the DHS CYF Field Screen Policy, decisions related to Call Screening's assignment of field screening, and supervisory decisions related to attempts to locate the family in order to conduct a safety assessment of the child
Teaming	• Update protocol with city law enforcement regarding joint investigations of cases involving child deaths • Determine order of reporting responsibility to law enforcement for medical providers or medical examiners' office in circumstances of child deaths • Reports barriers to inter-county cooperation to PA DPW OCYF Western Region
Intervention Adequacy and Resource Availability	• Development of placement resources for adolescents involved in high-risk lifestyles (e.g., gang involvement) • Requirement for contracted providers to check for smoke detectors in homes • Develop written plan for child care when custodial parent is at work • Resources to families without appropriate sleeping accommodations for infants